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(54) **BALLOON SIZING DEVICE AND METHOD OF POSITIONING A PROSTHETIC HEART VALVE**

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See application file for complete search history.

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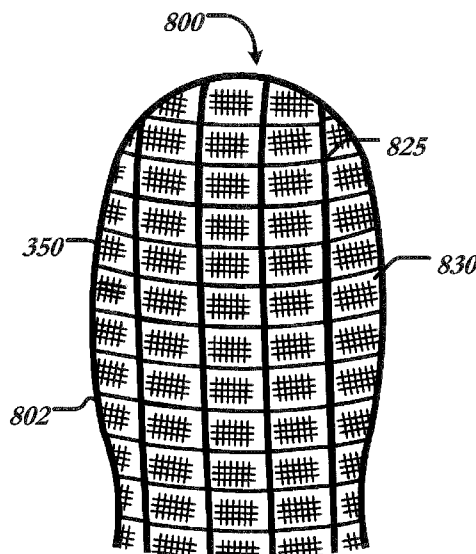
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(57) **ABSTRACT**

A sizing device for a collapsible prosthetic heart valve, the sizing device includes a collapsible and expandable balloon having a proximal end, a distal end. At least one microelectromechanical sensor is coupled to the balloon, the at least one sensor being capable of measuring information related to size and stiffness of tissue.

**11 Claims, 9 Drawing Sheets**



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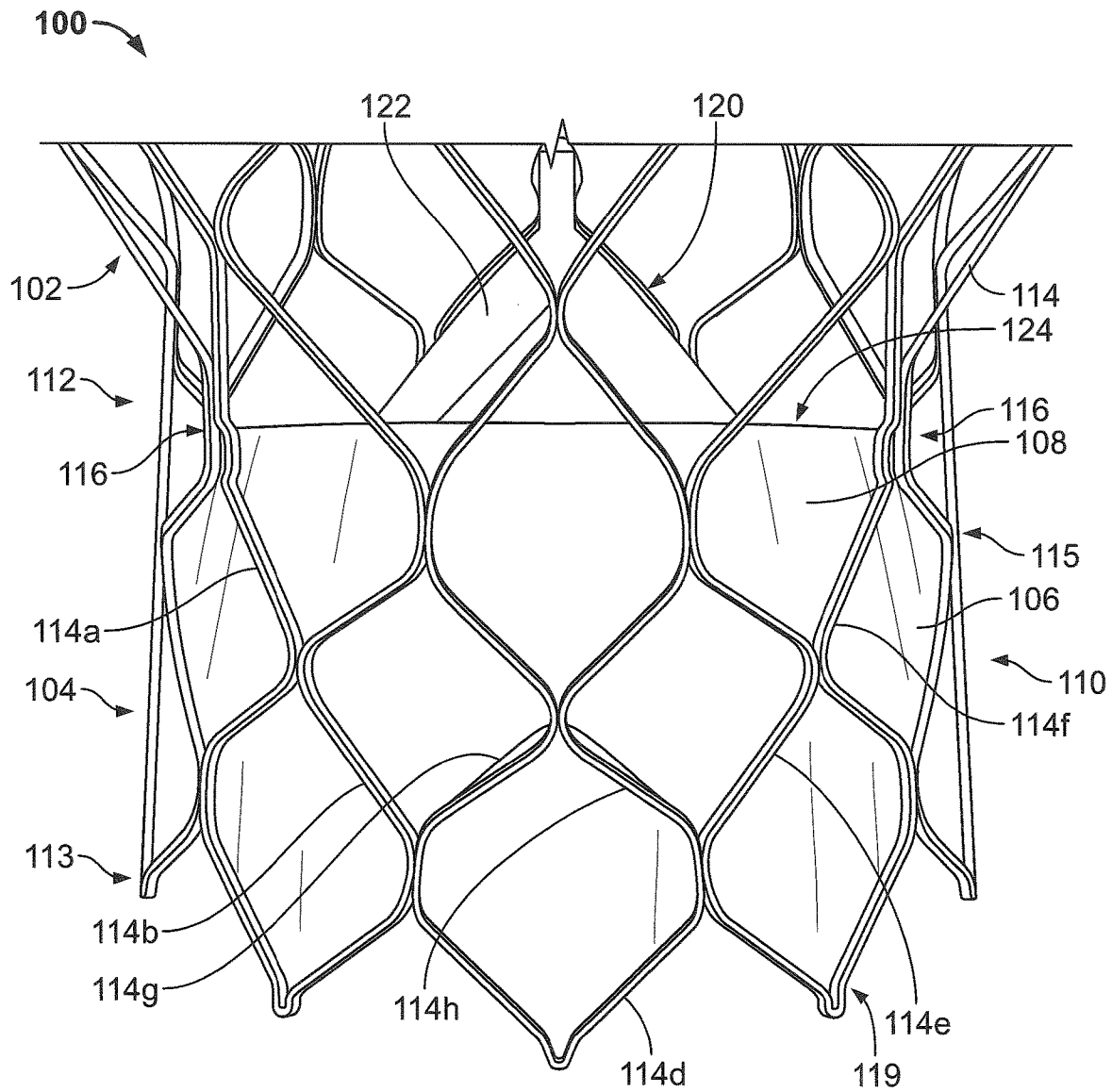


FIG. 1

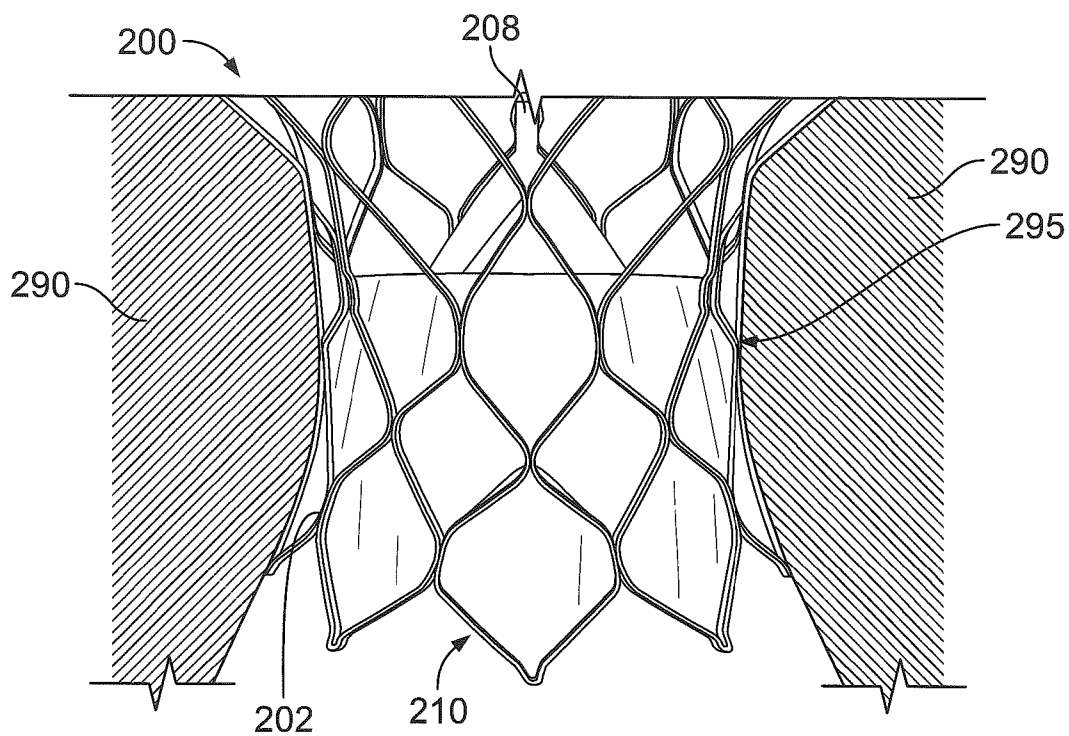


FIG. 2A

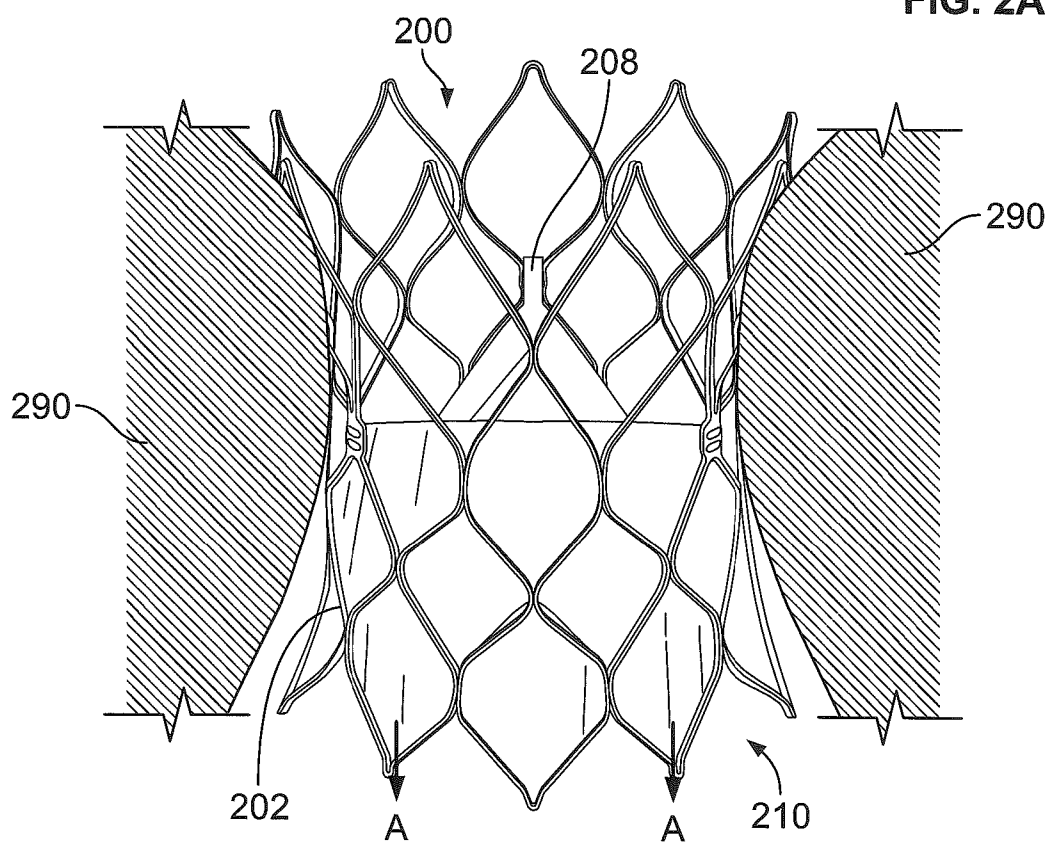


FIG. 2B

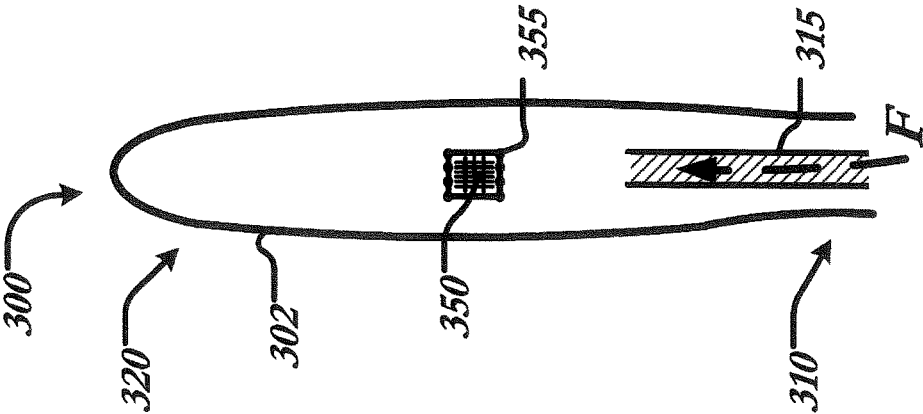


FIG. 3A

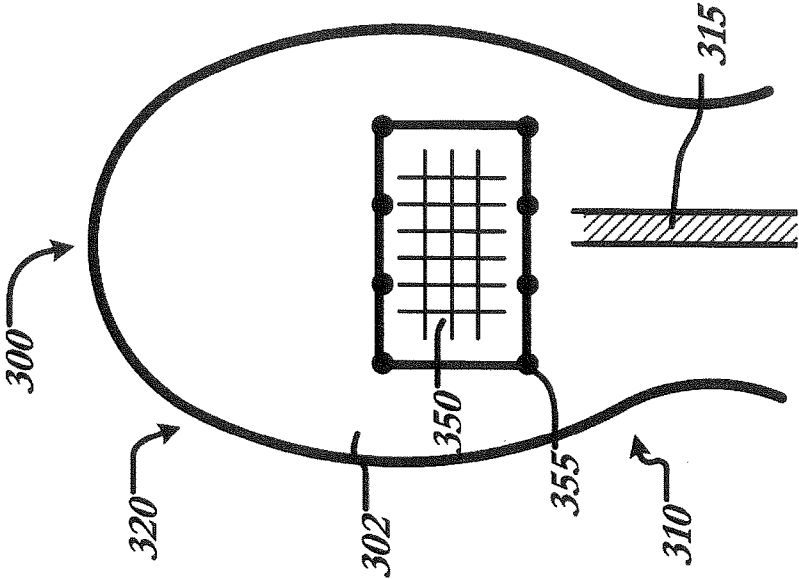


FIG. 3B

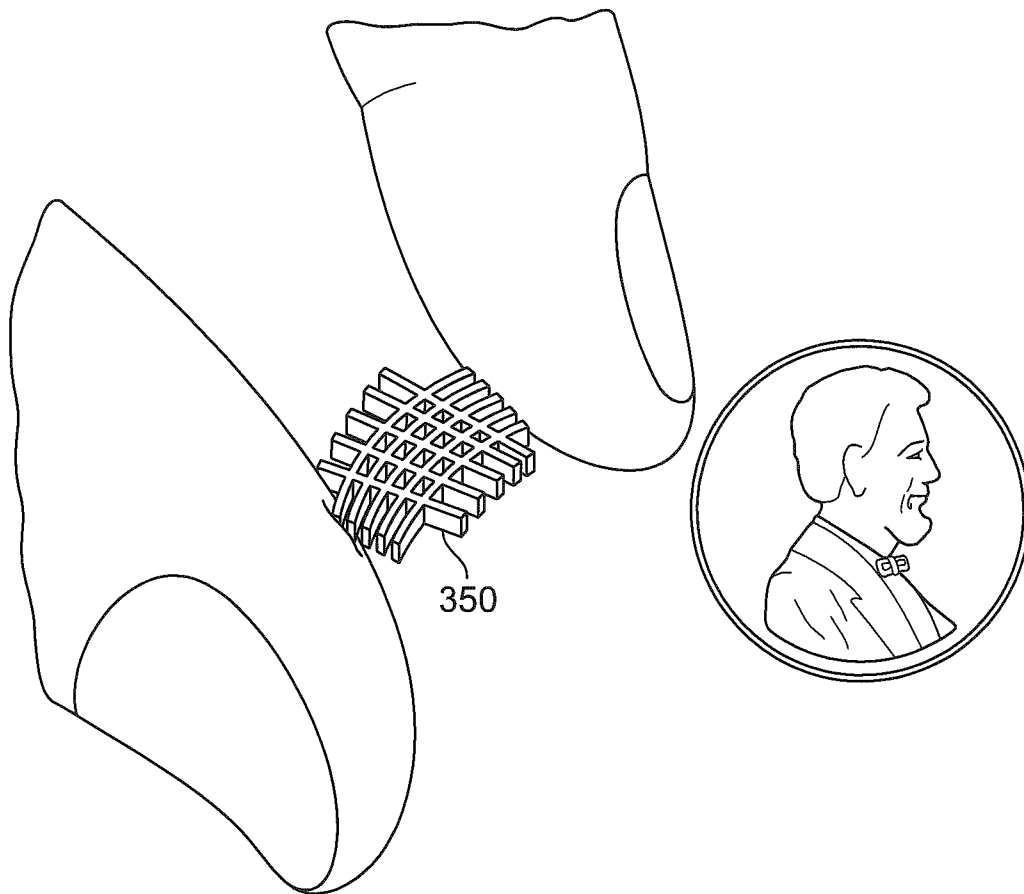


FIG. 4

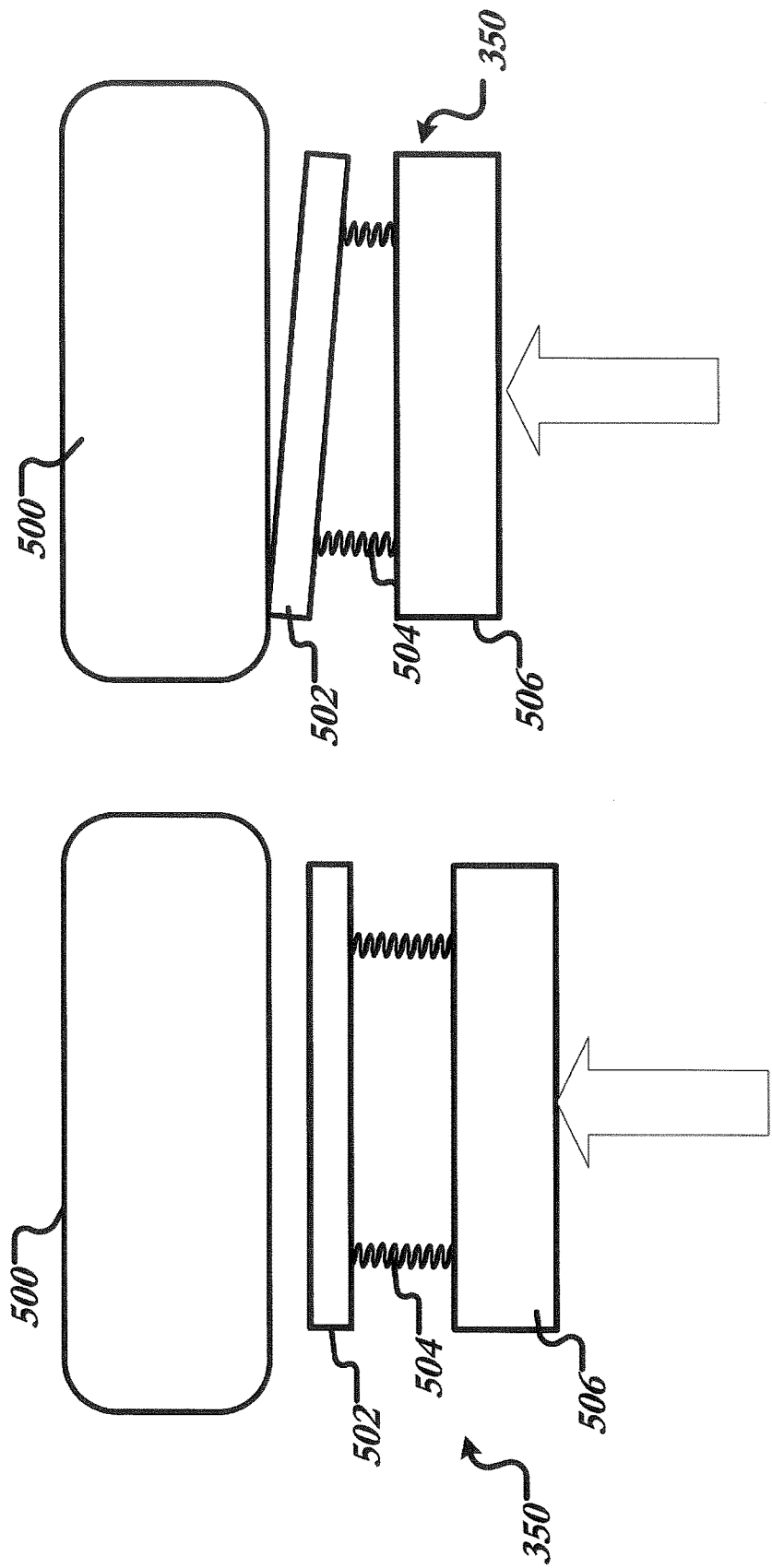
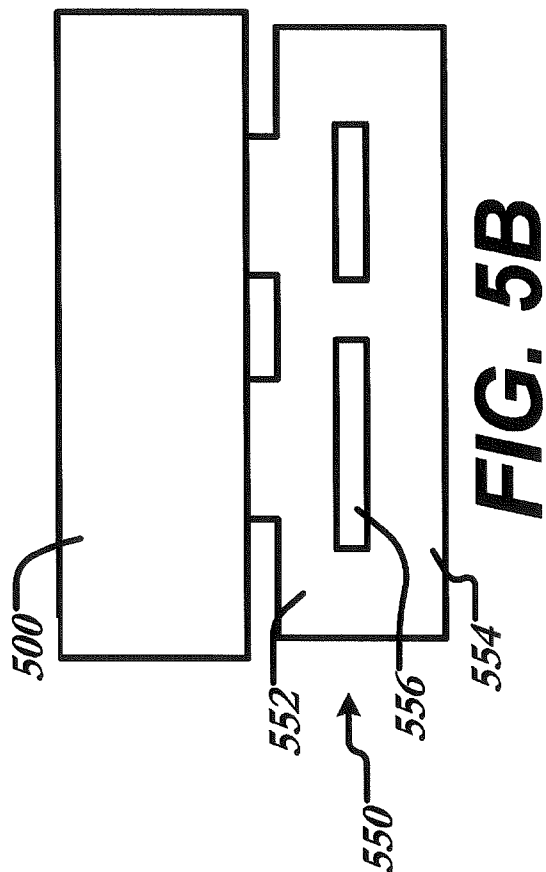
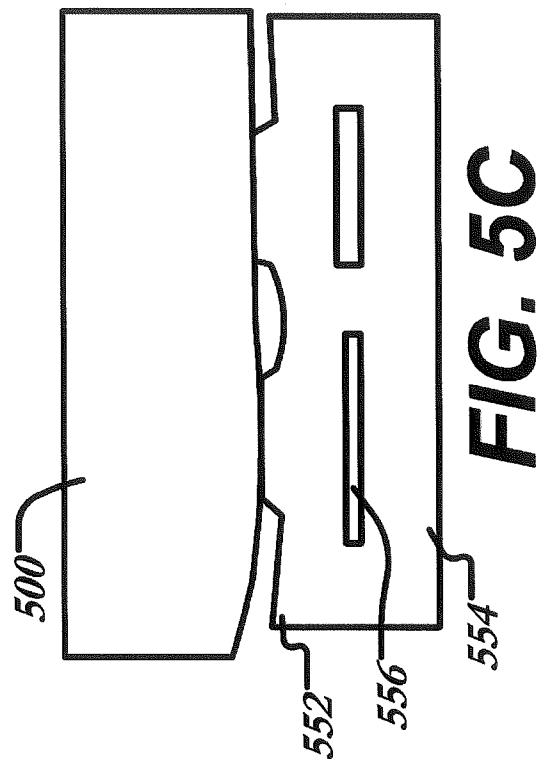


FIG. 5A





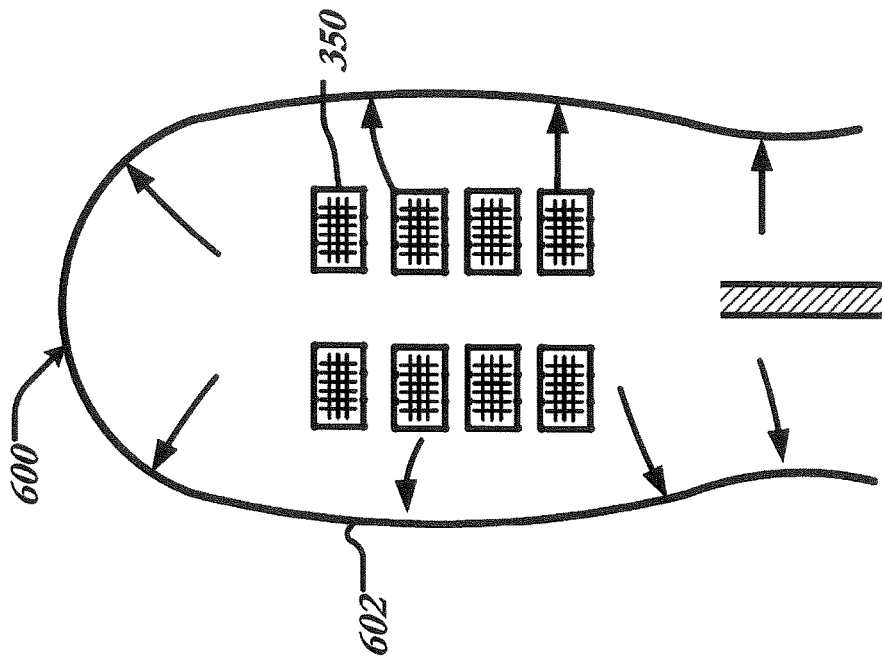


FIG. 6A

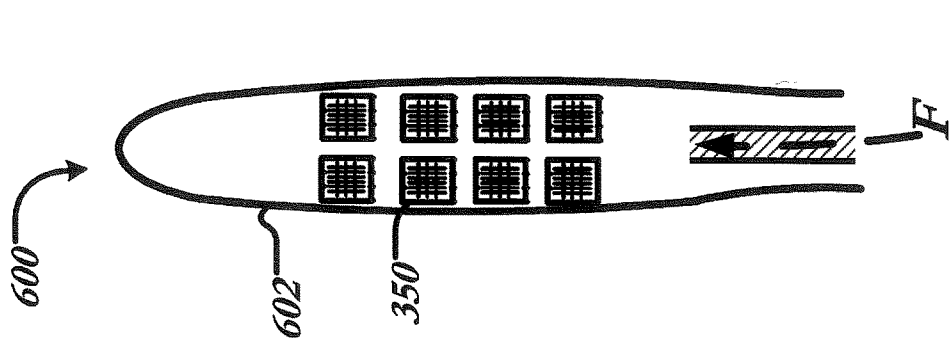
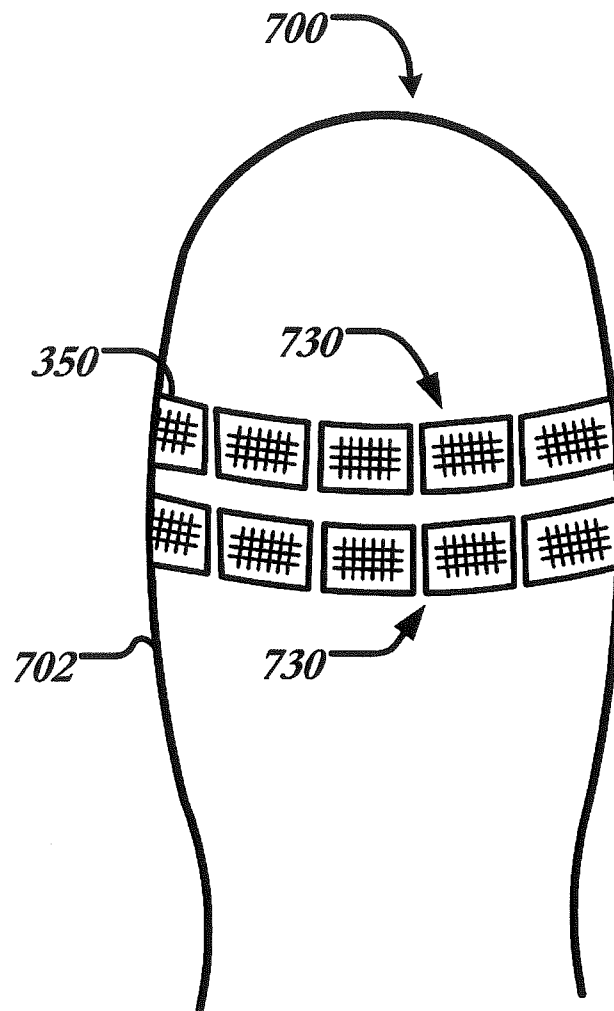
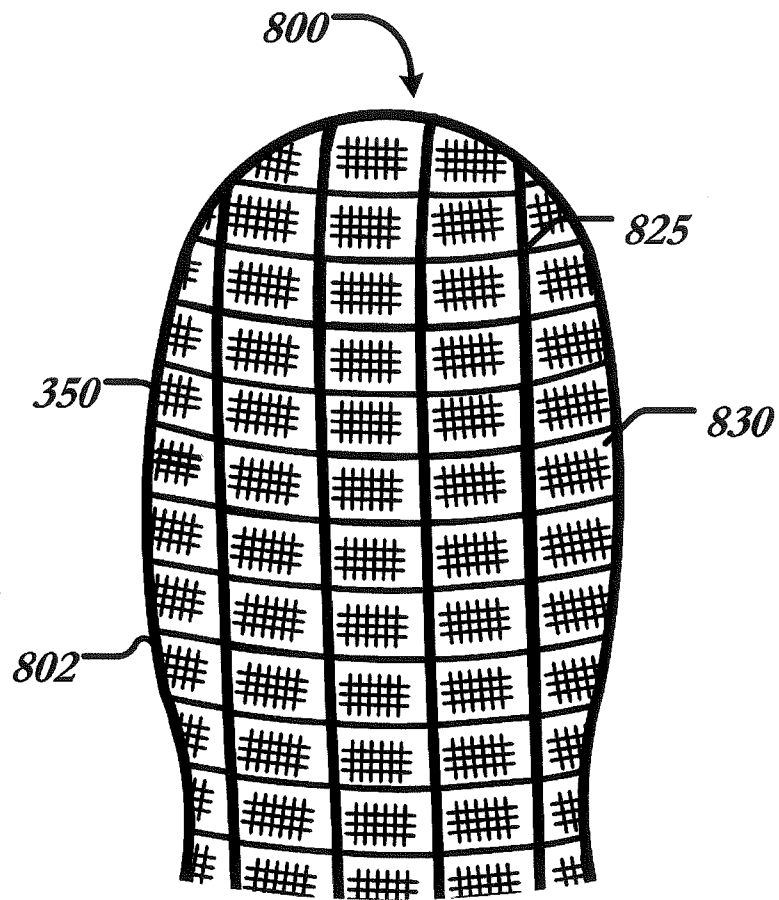


FIG. 6B

**FIG. 7**

**FIG. 8**

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# BALLOON SIZING DEVICE AND METHOD OF POSITIONING A PROSTHETIC HEART VALVE

## CROSS REFERENCE TO RELATED APPLICATION

The application claims the benefit of the filing date of U.S. Provisional Patent Application No. 61/667,578 filed Jul. 3, 2012, the disclosure of which is hereby incorporated herein by reference.

## BACKGROUND OF THE INVENTION

The present invention relates to heart valve replacement and, in particular, to collapsible prosthetic heart valves. More particularly, the present invention relates to devices and methods for sizing and positioning of collapsible prosthetic heart valves.

Prosthetic heart valves that are collapsible to a relatively small circumferential size can be delivered into a patient less invasively than valves that are not collapsible. For example, a collapsible valve may be delivered into a patient via a tube-like delivery apparatus such as a catheter, a trocar, a laparoscopic instrument, or the like. This collapsibility can avoid the need for a more invasive procedure such as full open-chest, open-heart surgery.

Collapsible prosthetic heart valves typically take the form of a valve structure mounted on a stent. There are two types of stents on which the valve structures are ordinarily mounted: a self-expanding stent or a balloon-expandable stent. To place such valves into a delivery apparatus and ultimately into a patient, the valve must first be collapsed or crimped to reduce its circumferential size.

When a collapsed prosthetic valve has reached the desired implant site in the patient (e.g., at or near the annulus of the patient's heart valve that is to be replaced by the prosthetic valve), the prosthetic valve can be deployed or released from the delivery apparatus and re-expanded to full operating size. For balloon-expandable valves, this generally involves releasing the entire valve, and then expanding a balloon positioned within the valve stent. For self-expanding valves, on the other hand, the stent automatically expands as the sheath covering the valve is withdrawn.

Despite the various improvements that have been made to the collapsible prosthetic heart valve delivery process, conventional delivery devices, systems, and methods suffer from some shortcomings. For example, in conventional delivery devices for self-expanding valves, clinical success of the valve is dependent on accurate deployment, anchoring and acceptable valve performance. Inaccurate sizing and positioning increases risks such as valve migration, which may result in severe complications due to obstruction of the left ventricular outflow tract and may even result in patient death. Additionally, calcification of the aortic valve may affect performance. Specifically, the degree of calcification may be important for patient selection criteria for valve implantation. Calcification has also been suggested as playing a role in anchoring transcatheter implants. The interaction between the implanted valve and the calcified tissue is believed to be relevant to anchoring the valve in place and preventing valve migration.

Without being bound to any particular theory, it is believed that improper anchoring of the valve may occur due to a mismatch between the size of the native annulus and the size of the prosthetic valve (e.g., using a small size valve in a large annulus), lower calcification levels in the native

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tissue than actually predicted, or improper positioning of the valve resulting in insufficient expansion of the valve diameter. Moreover, overestimation of the annulus size may cause an oversized valve to be implanted, leading to local complications in the aortic root, including coronary orifice obstruction, aortic dissection and heart blockage. Additionally, oversized valves may cause extended compression and/or stent deformation that affects valve durability.

In addition, incorrect sizing of a valve due to anatomical variations between patients may require removal of a fully deployed heart valve from the patient if it appears that the valve is not functioning properly. Removing a fully deployed heart valve increases the length of the procedure and increases the risk of infection and/or damage to heart tissue. Thus, methods and devices are desirable that would reduce the likelihood of removal. Methods and devices are also desirable that would reduce the likelihood of valve migration caused by improper anchoring.

Current methods for estimating the size of a patient's anatomy include imaging techniques such as transthoracic echocardiograms, trans-esophageal echocardiograms and angiography. These imaging methods are not standardized and may yield inconsistent results due to the elliptical shape of the target anatomy. Additionally, none of these techniques allow for contact forces between the annulus and stent to be measured and, thus they do not account for calcification.

There therefore is a need for further improvements to the devices, systems, and methods for transcatheter delivery and positioning of collapsible prosthetic heart valves. Specifically, there is a need for further improvements to the devices, systems, and methods for accurately measuring the native annulus dimensions and calcification levels in a patient. Such accurate measurement will help to reduce the risks associated with valve migration and improper valve positioning. Among other advantages, the present invention may address one or more of these needs.

## SUMMARY OF THE INVENTION

In one embodiment, a sizing device for a collapsible prosthetic heart valve may include a collapsible and expandable balloon and at least one microelectromechanical sensor attached to the balloon, the at least one sensor being capable of measuring a property of tissue.

In some example, the device may include a conduit in fluid communication with the inside of the balloon for delivering a fluid to inflate the balloon. The balloon may include at least one of PET, Nylon, polyurethane or a thermoplastic elastomer. The at least one sensor may be capable of measuring data relating to native valve annulus diameter. The data may relate to the extent of calcification of tissue and may utilize capacitance to measure the information. The at least one sensor may include a piezoelectric material. The at least one sensor may include a polymer such as polydimethylsiloxane or a polyimide. The at least one sensor may also include a fabric. In some examples, the device may include a plurality of sensors arranged about the periphery of the balloon.

In another embodiment, a sizing device for a collapsible prosthetic heart valve includes a plurality of microelectromechanical sensors coupled end-to-end to form a collapsible and expandable balloon, the plurality of sensors being capable of measuring a property of tissue. The plurality of sensors may be capable of measuring data relating to native valve annulus diameter. The plurality of sensors may be capable of measuring data relating to the extent of calcification of tissue.

A method for determining the proper fitment of a heart valve within a native aortic annulus may include the steps of introducing a sizing device to the native annulus, the sizing device including (i) a collapsible and expandable balloon, and (ii) at least one microelectromechanical sensor attached to the balloon, expanding the diameter of the balloon within the native annulus, and acquiring data related to a property of tissue using the at least one microelectromechanical sensor.

In some example, the data may relate to an annulus diameter. The data may relate to an extent of calcification. In some examples, the method further includes a conduit in fluid communication with the inside of the balloon for inflating the balloon, and wherein expanding the diameter of the sizing device comprises injecting a fluid through the conduit to the inside of the balloon. The method may further include the step of deflating the balloon and removing the sizing device from the native annulus.

#### BRIEF DESCRIPTION OF THE DRAWINGS

Various embodiments of the present invention are described herein with reference to the drawings, wherein:

FIG. 1 is a side elevational view of a conventional prosthetic heart valve;

FIG. 2A is a highly schematic side elevational view of a prosthetic heart valve having poor fitment in a native valve annulus;

FIG. 2B is a highly schematic side elevational view of a prosthetic heart valve that has migrated from its implantation position in the native annulus;

FIG. 3A is a side view of an expandable balloon having a microelectromechanical sensor according to a first embodiment of the present invention;

FIG. 3B is a side view of the balloon of FIG. 3A after inflation;

FIG. 4 is a perspective view of a microelectromechanical sensor;

FIG. 5A is a highly schematic view illustrating the sensing of a microelectromechanical sensor;

FIGS. 5B and 5C illustrate microelectromechanical sensor formed of a capacitive pair;

FIG. 6A is a side view of a collapsed balloon having microelectromechanical sensors according to a second embodiment of the present invention;

FIG. 6B is a side view of the balloon of FIG. 6A after inflation;

FIG. 7 is a side view of an inflatable balloon having microelectromechanical sensors arranged in rings according to a third embodiment of the present invention; and

FIG. 8 is a side view of an inflatable balloon formed of microelectromechanical sensors according to a fourth embodiment of the present invention.

Various embodiments of the present invention will now be described with reference to the appended drawings. It is appreciated that these drawings depict only some embodiments of the invention and are therefore not to be considered limiting of its scope.

#### DETAILED DESCRIPTION OF THE INVENTION

As used herein, the term “proximal,” when used in connection with a prosthetic heart valve, refers to the portion or end of the heart valve closest to the heart when the heart valve is implanted in a patient, whereas the term “distal,” when used in connection with a prosthetic heart valve, refers

to the portion or end of the heart valve farthest from the heart when the heart valve is implanted in a patient. When used in connection with devices for delivering a prosthetic heart valve into a patient, the terms “proximal” and “distal” are to be taken as relative to the user of the delivery devices. “Proximal” is to be understood as relatively close to the user, and “distal” is to be understood as relatively farther away from the user.

FIG. 1 shows a conventional collapsible prosthetic heart valve **100**. The prosthetic heart valve **100** is designed to replace the function of a native aortic valve of a patient. Examples of collapsible prosthetic heart valves are described in International Patent Application Publication No. WO/2009/042196; U.S. Pat. No. 7,018,406; and U.S. Pat. No. 7,329,278, the disclosures of all of which are hereby incorporated herein by reference. As discussed in detail below, the prosthetic heart valve has an expanded condition and a collapsed condition. Although the invention is described herein as applied to a prosthetic heart valve for replacing a native aortic valve, the invention is not so limited, and may be applied to prosthetic valves for other cardiac applications.

The prosthetic heart valve **100** includes a stent or frame **102**, which may be wholly or partly formed of any biocompatible material, such as metals, synthetic polymers, or biopolymers capable of functioning as a stent. Suitable biopolymers include, but are not limited to, elastin, and mixtures or composites thereof. Suitable metals include, but are not limited to, cobalt, titanium, nickel, chromium, stainless steel, and alloys thereof, including nitinol. Suitable synthetic polymers for use as a stent include, but are not limited to, thermoplastics, such as polyolefins, polyesters, polyamides, polysulfones, acrylics, polyacrylonitriles, polyetheretherketone (PEEK), and polyaramides. The stent **102** may have an annulus section **110** and an aortic section (not shown). Each of the annulus section **110** and the aortic section of the stent **102** includes a plurality of cells **112** connected to one another around the stent. The annulus section **110** and the aortic section of the stent **102** may include one or more annular rows of cells **112** connected to one another. For instance, the annulus section **110** may have two annular rows of cells **112**. When the prosthetic heart valve **100** is in the expanded condition, each cell **112** may be substantially diamond shaped. Regardless of its shape, each cell **112** is formed by a plurality of struts **114**. For example, a cell **112** may be formed by four struts **114**.

The stent **102** may include commissure points **116** connecting at least two cells **112** in the longitudinal direction of the stent **102**. The commissure points **116** may include eyelets for facilitating the suturing of a valve assembly **104** to the stent **102**.

The prosthetic heart valve **100** also includes a valve assembly **104** attached inside the annulus section **110** of the stent **102**. United States Patent Application Publication No. 2008/0228264, filed Mar. 12, 2007, and United States Patent Application Publication No. 2008/0147179, filed Dec. 19, 2007, the entire disclosures of both of which are hereby incorporated herein by reference, describe suitable valve assemblies. The valve assembly **104** may be wholly or partly formed of any suitable biological material or polymer. Examples of biological materials suitable for the valve assembly **104** include, but are not limited to, porcine or bovine pericardial tissue. Examples of polymers suitable for the valve assembly **104** include, but are not limited to, polyurethane and polyester.

The valve assembly **104** may include a cuff **106** disposed on the luminal surface of annulus section **110**, on the

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abluminal surface of annulus section 110, or on both surfaces, and the cuff may cover all or part of either or both of the luminal and abluminal surfaces of the annulus section. FIG. 1 shows cuff 106 disposed on the luminal surface of annulus section 110 so as to cover part of the annulus section while leaving another part thereof uncovered. The valve assembly 104 may further include a plurality of leaflets 108 which collectively function as a one-way valve. A first edge 122 of each leaflet 108 may be attached to the cuff 106 or the stent 102 by any suitable attachment means, such as suturing, stapling, adhesives or the like. For example, the first edge 122 of each leaflet 108 may be attached to the cuff 106, and the cuff may in turn be attached to the stent 102. Alternatively, the first edge 122 of each leaflet 108 may be sutured to the stent 102 by passing strings or sutures through the cuff 106 of the valve assembly 104. A second or free edge 124 of each leaflet 108 may coapt with the corresponding free edges of the other leaflets, thereby enabling the leaflets to function collectively as a one-way valve.

Irrespective of the attachment means employed, the leaflets 108 may be attached to the cuff 106 or to the stent 102 along at least some struts 114 of the stent to enhance the structural integrity of the valve assembly 104. As a consequence of this attachment, the struts 114 help support the leaflets 108 of the valve assembly 104 and may therefore reduce the strain in the leaflet-cuff junction.

In operation, the embodiment of the prosthetic heart valve described above may be used to replace a native heart valve, such as the aortic valve. The prosthetic heart valve may be delivered to the desired site (e.g., near a native aortic annulus) using any suitable delivery device. Typically, during delivery, the prosthetic heart valve is disposed inside the delivery device in the collapsed condition. The delivery device may be introduced into a patient using a transfemoral, transapical, transseptal or other approach. Once the delivery device has reached the target site, the user may deploy the prosthetic heart valve. Upon deployment, the prosthetic heart valve expands, preferably into secure engagement within the native aortic annulus. When the prosthetic heart valve is properly positioned inside the heart, it works as a one-way valve, allowing blood to flow in one direction and preventing blood from flowing in the opposite direction.

Problems may be encountered when implanting the prosthetic heart valve. For example, in certain procedures, collapsible valves may be implanted in a native valve annulus without first resecting the native valve leaflets. The collapsible valves may have critical clinical issues because of the nature of the stenotic leaflets that are left in place. Additionally, patients with uneven calcification, bi-cuspid disease, and/or valve insufficiency could not be treated well, if at all, with the current collapsible valve designs.

The reliance on evenly calcified leaflets for proper valve placement and seating could lead to several problems, such as: (1) perivalvular leakage (PV leak), (2) valve migration, (3) mitral valve impingement, (4) conduction system disruption, (5) coronary blockage, etc., all of which can have severely adverse clinical outcomes. To reduce these adverse events, the optimal valve would seal and anchor adequately without the need for excessive radial force, protrusion into the left ventricular outflow tract (LVOT), etc., that could harm nearby anatomy and physiology.

FIG. 2A illustrates a prosthetic heart valve 200 having poor fitment within native valve annulus 290. Specifically, as seen in FIG. 2A, the annulus section 210 of the stent 202 is distorted near deformed portion 295. Improper fitment of the prosthetic heart valve 200 may lead to any of the problems discussed above. In addition, as the stent 202 of

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collapsible prosthetic heart valve 200 distorts during implantation, during beating of the heart, or because of irregularities in the patient's anatomy or the condition of the native valve, such distortion may be translated to the valve assembly, such that not all of the valve leaflets 208 meet to form effective coaptation junctions. This can result in leakage or regurgitation and other inefficiencies which can reduce cardiac performance. Moreover, if the prosthetic valve 200 is not placed optimally and the valve leaflets 208 are not coapting as intended, other long term effects, such as uneven wear of the individual leaflets 208, can be postulated. Such improper fitment may be due to poor positioning, disregard for calcification or use of the wrong valve size.

Poor positioning, disregard for calcification or the use of the wrong valve size may also cause heart valve migration. As seen in FIG. 2B, prosthetic heart valve 200 has partially translated into the ventricle from its intended location at native valve annulus 290, a condition that may lead to a host of problems as discussed above. Even a small shift in position as indicated by arrows "A" may cause inadequate sealing and improper valve function. Migration may also result in regurgitation of blood passing through the valve.

In order to avoid these problems, a valve sizing device may be used to accurately determine the annulus diameter and the calcification levels in the aortic valve. The valve sizing device may be deployed first within the native valve sinus to determine the size, shape and condition of the sinus. After obtaining sufficient measurements, the valve sizing device may be removed from the native valve sinus and a suitable prosthetic heart valve may be chosen based on the obtained measurements. The selected prosthetic heart valve may then be implanted with a reduced risk of deformation and/or migration.

FIG. 3 illustrates a valve sizing device 300 according to a first embodiment of the present invention. The valve sizing device 300 includes an expandable balloon 302 and a sensor 350 attached to the wall of the balloon 302. The balloon 302 may have a proximal end 310 and a distal end 320, and may be wholly or partly formed of PET, Nylon, polyurethane, a thermoplastic elastomer or combinations thereof. Sensor 350 may be a microelectromechanical sensor and may include but is not limited to sensors capable of measuring capacitance, piezoelectricity or any other suitable parameter. Sensor 350 may also include a flexible tactile microelectromechanical sensor.

Sensor 350 may be embedded within balloon 302 or coupled to the balloon in any suitable manner and at various points on the wall of the balloon. For example, sensor 350 may be coupled to balloon 302 at junctions 355 using an adhesive or other suitable method. Deformation of balloon 302 may cause a corresponding deformation in sensor 350 and thus the sensor may comply with intravascular geometry. It will be understood that more than one sensor 350 may be coupled to balloon 302 as will be seen in the embodiments described below. For example, two or three sensors 350 may be evenly disposed about the circumference of balloon 302. The sensors 350 may be disposed on the periphery of balloon 302 so that they are capable of contacting body tissue upon inflation of the balloon.

Prior to insertion into a patient, balloon 302 may be folded into the collapsed condition shown in FIG. 3A, for example, using a pleat fold or a T-fold. Once the sizing device 300 has been placed in the desired position within the patient, a fluid may be injected into the balloon 302 to expand the balloon to a suitable diameter. Specifically, balloon 302 may include a conduit 315 for carrying a fluid from a fluid source (not

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shown) to the interior of the balloon. Inflation fluids may be a gas, such as helium or carbon dioxide, or a liquid, such as saline.

In its fully expanded condition, balloon **302** may have a generally circular cross-section, although other cross-sectional shapes are contemplated, including triangular, rectangular, trapezoidal, elliptical, curved, and other polygonal and non-polygonal shapes. When fully expanded balloon **302** has a cross-sectional size that is greater than the cross-sectional size of aortic sinus. This will ensure that balloon **302** fully contacts the native tissue around substantially the entirety of the sinus so that the size of the sinus can be determined accurately.

By knowing the material properties of the balloon **302** (e.g., elasticity, etc.) and the volume of fluid being introduced through fluid conduit **315**, the diameter or the cross-section of balloon **302** may be estimated. In at least some examples, the balloon **302** is inflated in vitro using known volumes of fluid and a plot is generated to establish the relationship between volume of fluid and cross-section of the balloon. This may be done by the manufacturer prior to shipping device **300**, or by the user at the surgical site. Once this relationship is known, the balloon **302** may be collapsed and inserted in vivo at the target site. A volume of fluid may be introduced and the diameter of the native valve annulus estimated based on the pre-established relationship. In addition, as the balloon **302** expands at the target site, sensors **350** begin to contact surrounding tissue and measure the forces generated by this contact.

FIG. **4** illustrates one possible configuration of a suitable microelectromechanical sensor **350**. As seen in FIG. **4**, sensor **350** may be flexible and deformable in order to collect information about size, shape and calcification of the native aortic valve. In that regard, sensor **350** may be fashioned from a fabric or flexible polymer such as polydimethylsiloxane or a polyimide having a pair of electrodes as will be described in greater detail with reference to FIGS. **5B** and **5C**.

FIG. **5A** is a schematic view illustrating the use of sensor **350** being used to measure calcification of tissue. Sensor **350** may include a contacting member **502**, a pair of springs **504** and a base layer **506**. Springs **504** may be connected to both the contacting member **502** and the base layer **506** and disposed between the two. It will be understood that springs **504** may be formed of springs having different spring constants. The sensor **350** may be positioned near target tissue **500** to measure the stiffness of the tissue. As can be appreciated from FIG. **5A**, sensor **350** may be brought in contact with tissue **500**, with contacting member **502** abutting the tissue. As the sensor **350** is gradually advanced, springs **504** begin to flex. By examining the force exerted on springs **504** and the displacement of the springs, the stiffness of tissue **500** may be determined. This stiffness measurement may then be used in turn to analyze the extent of calcification of the tissue and to choose the appropriate prosthetic heart valve for implanting in the patient.

This sensing concept may be implemented using a capacitor pair as shown in FIGS. **5B** and **5C**. As shown in these figures, capacitor **550** includes a top electrode **552**, a bottom electrode **554** and an air gap **556**. As seen in FIG. **5B**, air gaps **556** are formed of varying sizes analogous to the different springs discussed above with reference to FIG. **5A**. When the sensor is contacted by tissue **500** as seen in FIG. **5B**, relative deflection may be precisely measured by the capacitive change of each element as shown in FIG. **5C**.

The following will describe the use of sizing device **300** for sizing, positioning and selecting an appropriate pros-

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thetic heart valve. As an initial step, the balloon **302** of the sizing device **300** may first be expanded in vitro to determine the relationship between fluid volume and balloon diameter, as described above. The valve sizing device **300** may then be inserted into the patient in the collapsed condition and advanced to the desired site for valve replacement. For example, for transfemoral insertion, the sizing device **300** may be inserted into the patient's femoral artery and advanced intravascularly to the descending aorta and the site of the native aortic valve. If the sizing device **300** includes echogenic materials, it may be guided to the appropriate position using the assistance of three-dimensional echocardiography to visualize the sizing device **300** within the patient.

Once sizing device **300** has reached the desired site of measurement, the balloon **302** may be inflated to assume an expanded shape by introducing a fluid through the fluid conduit **315**. With balloon **302** in its expanded condition, measurements relating to the annulus diameter and/or calcification may be made using sensor **350**. After sufficient data has been collected or when the collected data shows that the walls of the native sinus have been reached, the balloon **302** may be collapsed by removing the fluid therefrom and the sizing device **300** may be removed from the patient's body. The collected data may then be used to select the appropriate prosthetic valve size and position, and the prosthetic valve may be deployed and anchored at the selected site using any manner known in the art. While the operation of the sizing device **300** of FIG. **3** has been described, it will be understood that other embodiments described below may be implemented in a similar manner.

FIG. **6A** illustrates a second embodiment of a valve sizing device **600**, similar to valve sizing device **300** of FIG. **3**, but having a plurality of sensors **350** attached to the wall of a balloon **602**. FIG. **6B** illustrates the sizing device **600** of FIG. **6A** in its expanded condition. FIGS. **6A** and **6B** illustrate six sensors **350** coupled to balloon **602**. It will be understood, however, that any number of sensors **350**, such as two, three, four, six or more sensors **350**, may be disposed on balloon **602**. As previously discussed, sensors **350** may be flexible and pliable so that they are capable of accommodating expansion of balloon **602**.

FIG. **7** is a side view of a valve sizing device **700** according to a third embodiment of the present invention, including an inflatable balloon **702** having a plurality of sensors **350** attached thereto. As illustrated in FIG. **7**, the plurality of sensors **350** are arranged about the periphery of balloon **702**. Specifically, sensors **350** may be arranged in rings **730** around the circumference of balloon **702**. By arranging the plurality of sensors **350** in rings **730**, the forces applied to the balloon **702** at any point around the circumference of the balloon may be measured. Although valve sizing device **700** includes two rings **730**, it will be understood that sensors **350** may be arranged in any number of rings around the circumference of balloon **702**.

FIG. **8** illustrates a fourth embodiment of a valve sizing device **800** including an inflatable balloon **802** formed of microelectromechanical sensors **350**. As will be appreciated from FIG. **8**, the balloon **802** may be formed by joining a plurality of sensors **350** to each other along seams **825** extending in both longitudinal and circumferential directions. Each sensor **350** may include a substrate **830** formed of a flexible material, such as rubber, fabric, a polyimide, or polydimethylsiloxane (PDMS). Substrates **830** may be joined together in edge-to-edge fashion along seams **825** to form a balloon **802**. The attachment along seams **825** may be made such that fluid is not able to pass between substrates.



In this manner, fluid can be introduced into balloon **802** for inflation through a fluid conduit (not shown) or any other suitable means. It will be understood that combinations of these embodiments may be possible. For example, a balloon may only be partially formed of sensors to reduce cost.

It will also be noted that while the inventions herein are predominately described in connection with the replacement of a tricuspid valve, the inventions are equally applicable to the replacement of other valves, including a bicuspid valve, such as the mitral valve. Moreover, the stent could have different shapes, such as a flared or conical annulus section, a less-bulbous aortic section, and the like, and a differently shaped transition section.

Moreover, although the invention herein has been described with reference to particular embodiments, it is to be understood that these embodiments are merely illustrative of the principles and applications of the present invention. It is therefore to be understood that numerous modifications may be made to the illustrative embodiments and that other arrangements may be devised without departing from the spirit and scope of the present invention as defined by the appended claims.

It will be appreciated that the various dependent claims and the features set forth therein can be combined in different ways than presented in the initial claims. It will also be appreciated that the features described in connection with individual embodiments may be shared with others of the described embodiments.

The invention claimed is:

1. A sizing device for a collapsible prosthetic heart valve, the sizing device comprising:

a plurality of microelectromechanical sensors, each of the plurality of microelectromechanical sensors being disposed on a flexible substrate, having a top electrode having a contacting surface, a bottom electrode, and an air gap disposed between the top electrode and the bottom electrode, the top electrode and the bottom electrode being deflectable relative to one another, and configured to measure capacitive changes to determine a relative deflection between the top electrode and the bottom electrode, each of the plurality of microelectromechanical sensors being capable of independently

measuring, with respect to others, a stiffness value of a native valve annulus by pressing against portions of the native valve annulus with the contacting surface, each flexible substrate being joined edge-to-edge along seams with adjacent substrates to form a collapsible and expandable balloon.

2. The device of claim 1, further comprising a conduit in fluid communication with the inside of the balloon for delivering a fluid to inflate the balloon.

3. The device of claim 2, wherein the balloon comprises at least one of PET, Nylon, polyurethane or a thermoplastic elastomer.

4. The device of claim 1, wherein the flexible substrate includes a polymer.

5. The device of claim 4, wherein the polymer includes polydimethylsiloxane.

6. The device of claim 4, wherein the polymer includes a polyimide.

7. The device of claim 1, wherein the flexible substrate includes a fabric.

8. The device of claim 1, wherein the plurality of microelectromechanical sensors are in contact with one another.

9. A sizing device for a collapsible prosthetic heart valve, the sizing device comprising a plurality of microelectromechanical sensors, each of the plurality of microelectromechanical sensors being disposed on a flexible substrate, the flexible substrate being directly coupled edge-to-edge along seams to adjacent substrates to form a collapsible and expandable balloon, each of the plurality of microelectromechanical sensors having a top electrode having a contacting surface, a bottom electrode, and an air gap disposed between the top electrode and the bottom electrode, the top electrode and the bottom electrode being deflectable relative to one another, and being capable of independently measuring, with respect to others, a property of tissue.

10. The device of claim 9, wherein each of the plurality of microelectromechanical sensors is capable of measuring data relating to native valve annulus diameter.

11. The device of claim 9, wherein each of the plurality of microelectromechanical sensors is capable of measuring data relating to the extent of calcification of tissue.

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