US 20250262426A1

(19) **United States**

(12) **Patent Application Publication** (10) **Pub. No.: US 2025/0262426 A1**

Feldman et al. (43) **Pub. Date: Aug. 21, 2025**

(54) **METHOD AND APPARATUS FOR ASSISTING A HEART**

(71) Applicants: **Marc David Feldman**, San Antonio, TX (US); **John Porterfield**, Austin, TX (US); **Clay Heighten**, Dallas, TX (US)

(72) Inventors: **Marc David Feldman**, San Antonio, TX (US); **John Porterfield**, Austin, TX (US); **Clay Heighten**, Dallas, TX (US)

(73) Assignees: **Board of Regents, The University of Texas System**, Austin, TX (US); **CardioVol, LLC**, Dallas, TX (US)

(21) Appl. No.: **19/197,941**

(22) Filed: **May 2, 2025**

Related U.S. Application Data

(60) Division of application No. 17/407,138, filed on Aug. 19, 2021, now Pat. No. 12,290,675, which is a continuation-in-part of application No. 17/238,167, filed on Apr. 22, 2021, now Pat. No. 11,918,799.

Publication Classification

(51) **Int. Cl.**

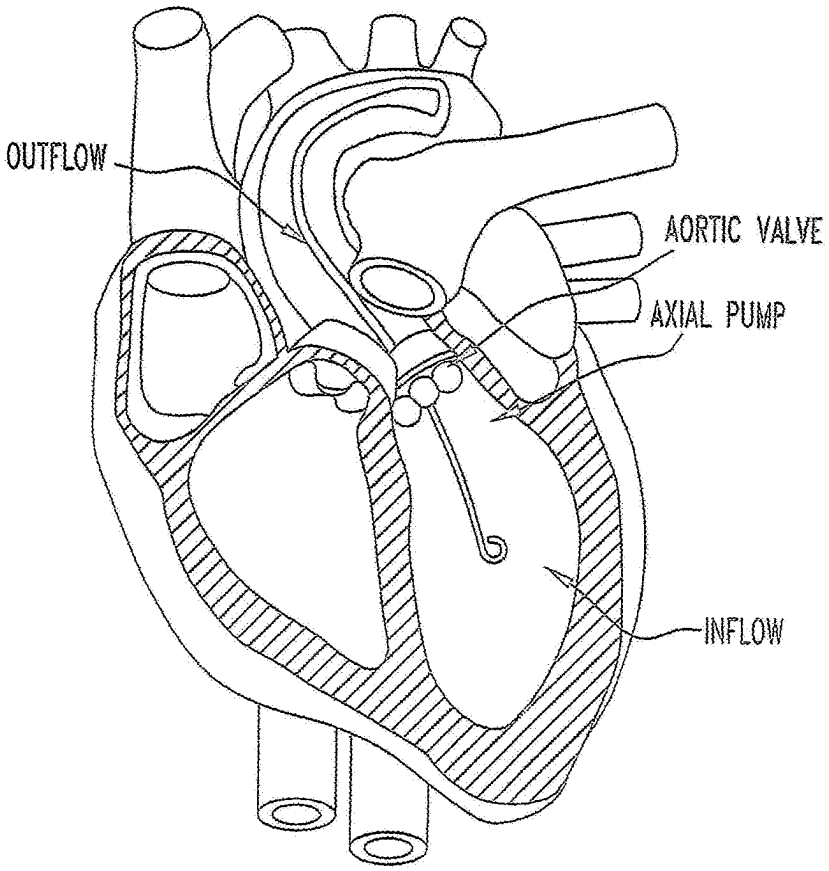
A61M 60/515	(2021.01)
A61M 60/113	(2021.01)
A61M 60/13	(2021.01)
A61M 60/139	(2021.01)
A61M 60/295	(2021.01)
A61M 60/38	(2021.01)
A61M 60/497	(2021.01)

(52) **U.S. Cl.**

CPC ***A61M 60/515*** (2021.01); ***A61M 60/113*** (2021.01); ***A61M 60/13*** (2021.01); ***A61M 60/139*** (2021.01); ***A61M 60/295*** (2021.01); ***A61M 60/38*** (2021.01); ***A61M 60/497*** (2021.01)

(57) **ABSTRACT**

An apparatus for a heart of a patient having a cardiac assist device adapted to be implanted into the patient to assist the heart with pumping blood. The apparatus has a sensor adapted to be implanted into the patient. The sensor in communication with the cardiac assist device and the heart which measures native volume of the heart. The apparatus has a first cardiac assist device and a second cardiac assist device tuned to maximize blood flow to the body of the patient, while resting the heart so the heart may recover function. Alternatively, the sensor monitors the heart based on admittance while the cardiac assist device. Alternatively, the sensor monitors the heart based on impedance.



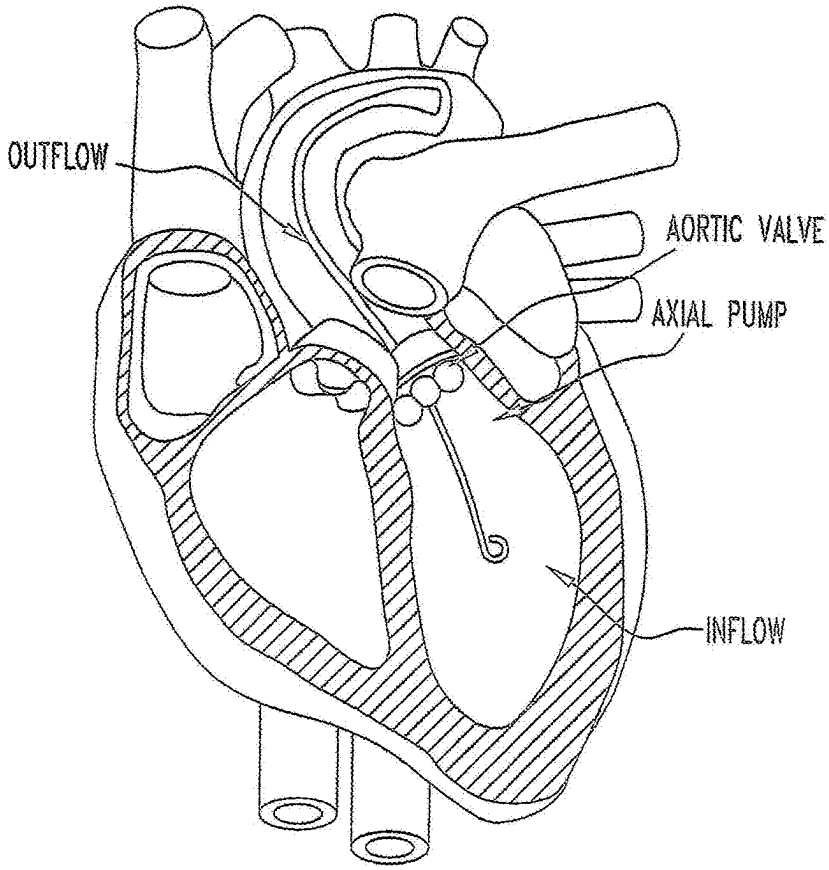

OUTFLOW
AORTIC VALVE
AXIAL PUMP
INFLOW

FIG. 1

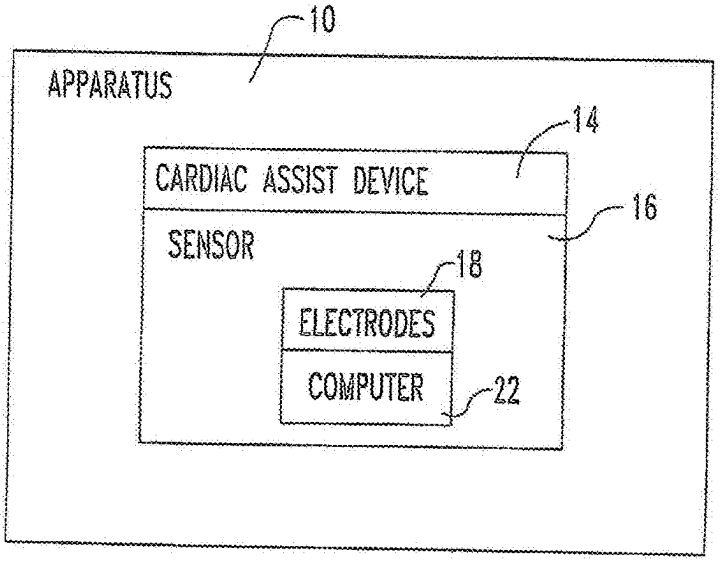

10
APPARATUS
14
CARDIAC ASSIST DEVICE
16
SENSOR
18
ELECTRODES
COMPUTER
22

FIG. 2

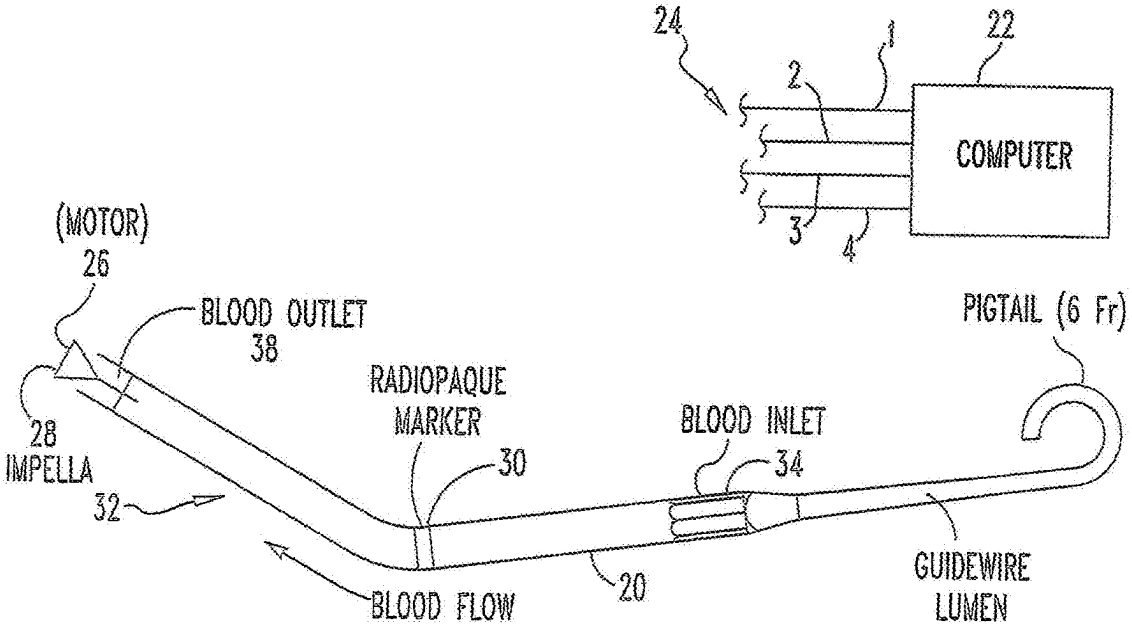

24
1
22
2
COMPUTER
3
4
(MOTOR)
26
BLOOD OUTLET
38
PIGTAIL (6 Fr)
RADIOPAQUE
MARKER
BLOOD INLET
28
IMPELLA
30
34
32
GUIDEWIRE
LUMEN
BLOOD FLOW
20

FIG. 3

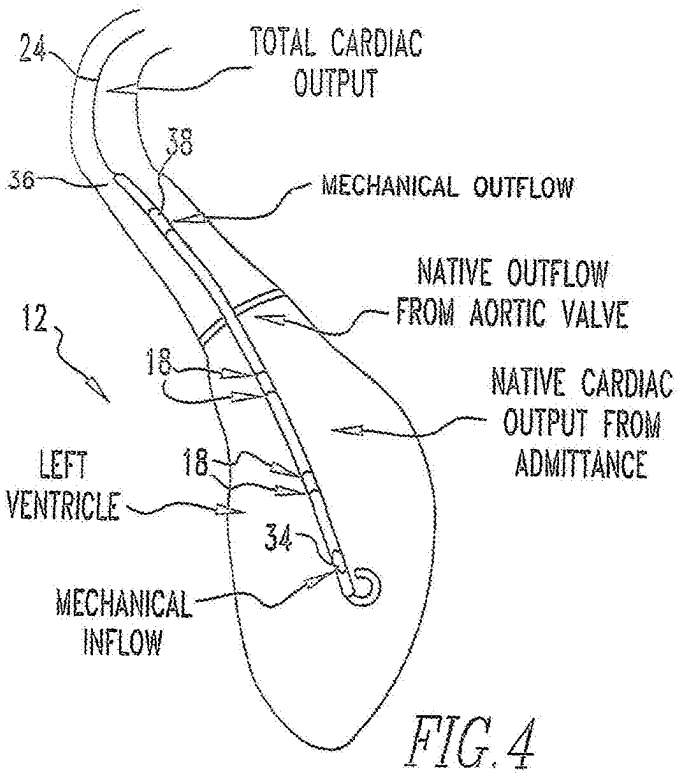

24
TOTAL CARDIAC
OUTPUT
38
36
MECHANICAL OUTFLOW
NATIVE OUTFLOW
FROM AORTIC VALVE
12
18
NATIVE CARDIAC
OUTPUT FROM
ADMITTANCE
LEFT
VENTRICLE
18
34
MECHANICAL
INFLOW

FIG. 4

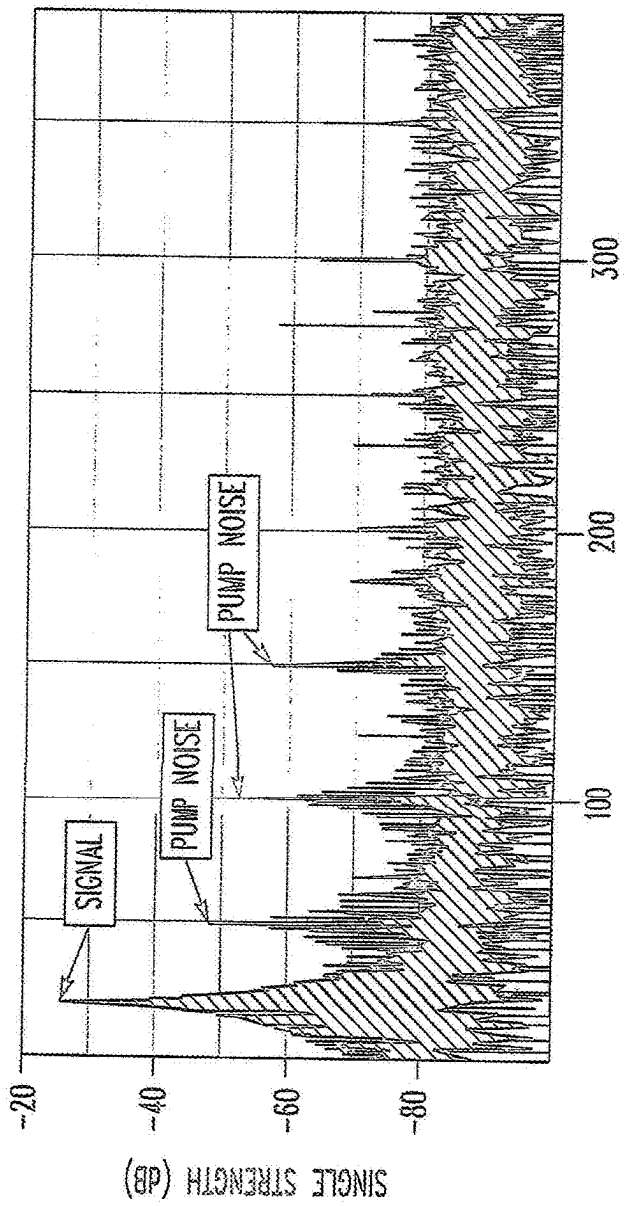

SIGNAL
PUMP NOISE
PUMP NOISE
-20
-40
-60
-80
SINGLE STRENGTH (dB)
100
200
300
FREQUENCY (kHz)

FIG. 5

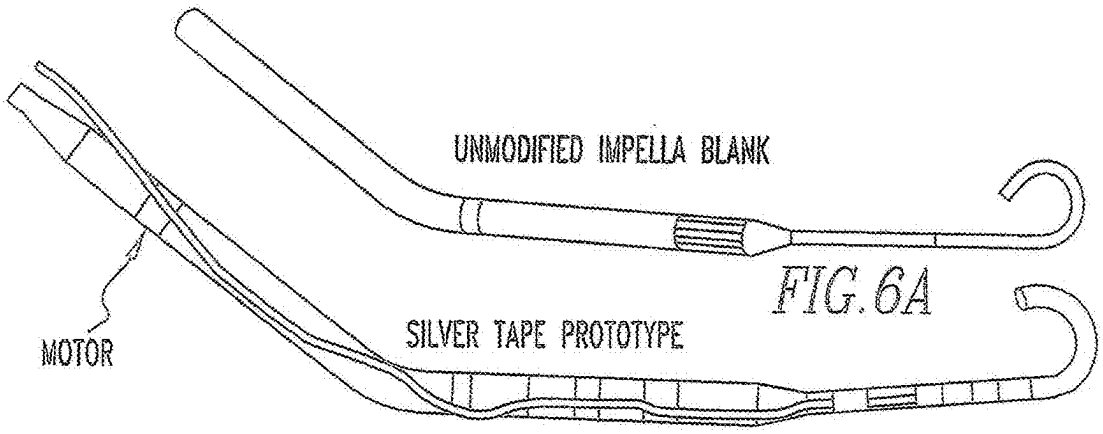


FIG. 6A

FIG. 6B

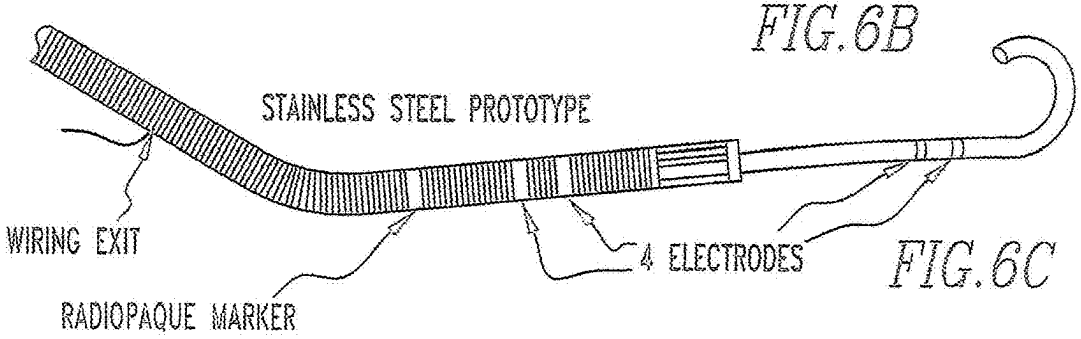


FIG. 6C

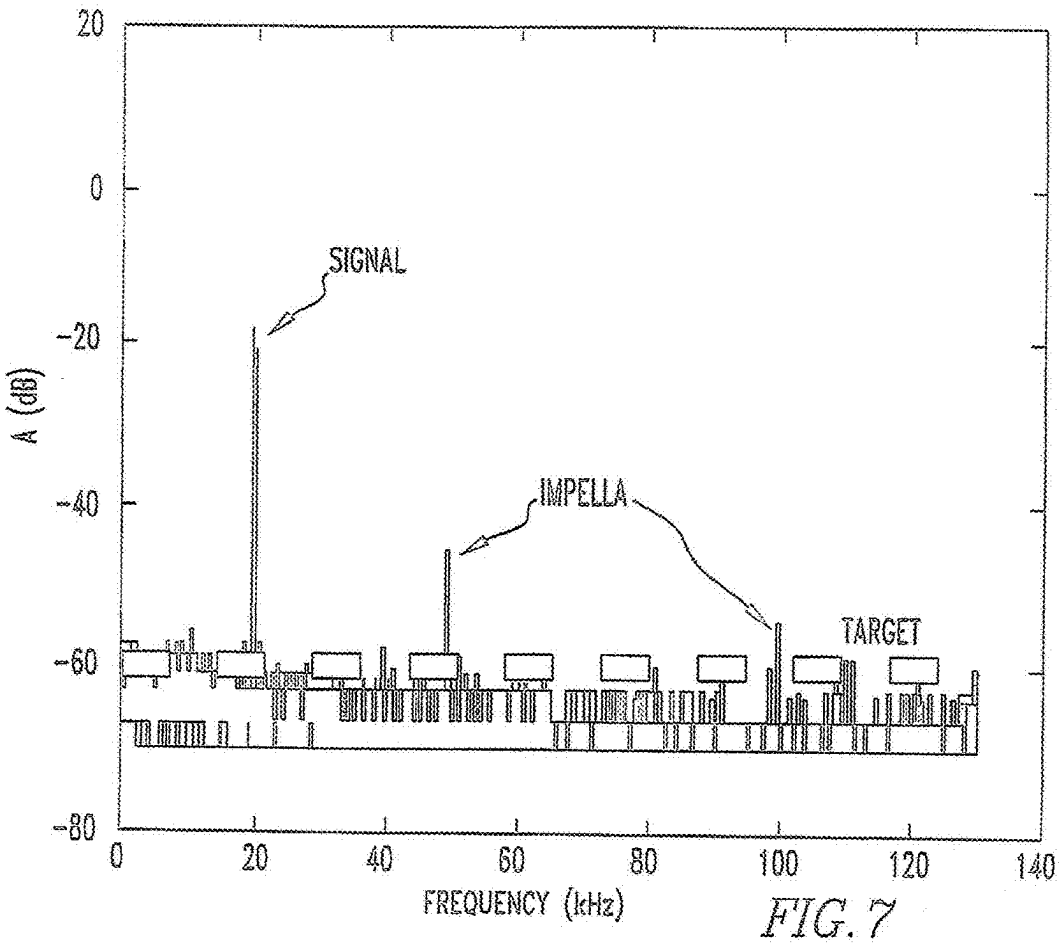


FIG. 7

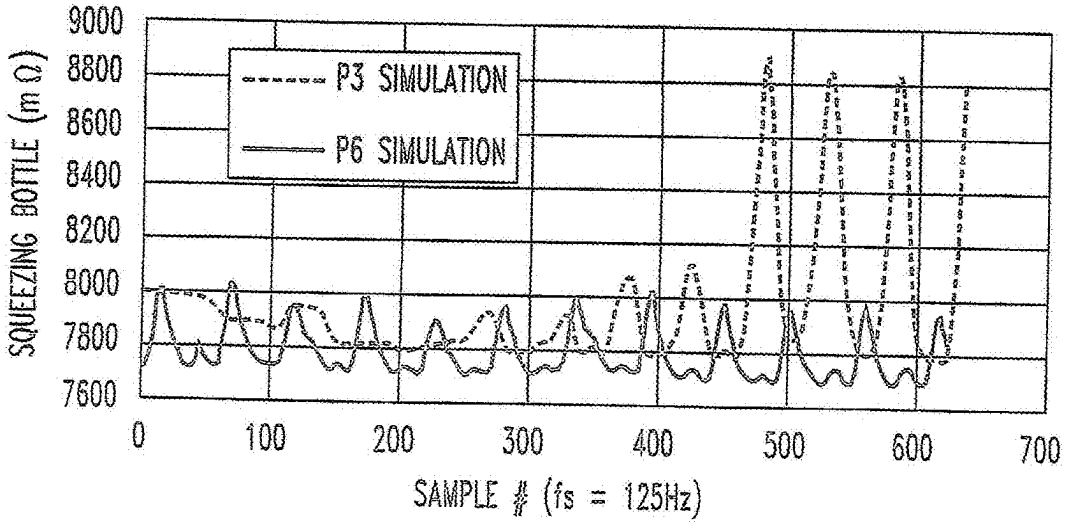

9000
8800
8600
8400
8200
8000
7800
7600
SQUEEZING BOTTLE (m Ω)
P3 SIMULATION
P6 SIMULATION
0
100
200
300
400
500
600
700
SAMPLE # (fs = 125Hz)

FIG.8

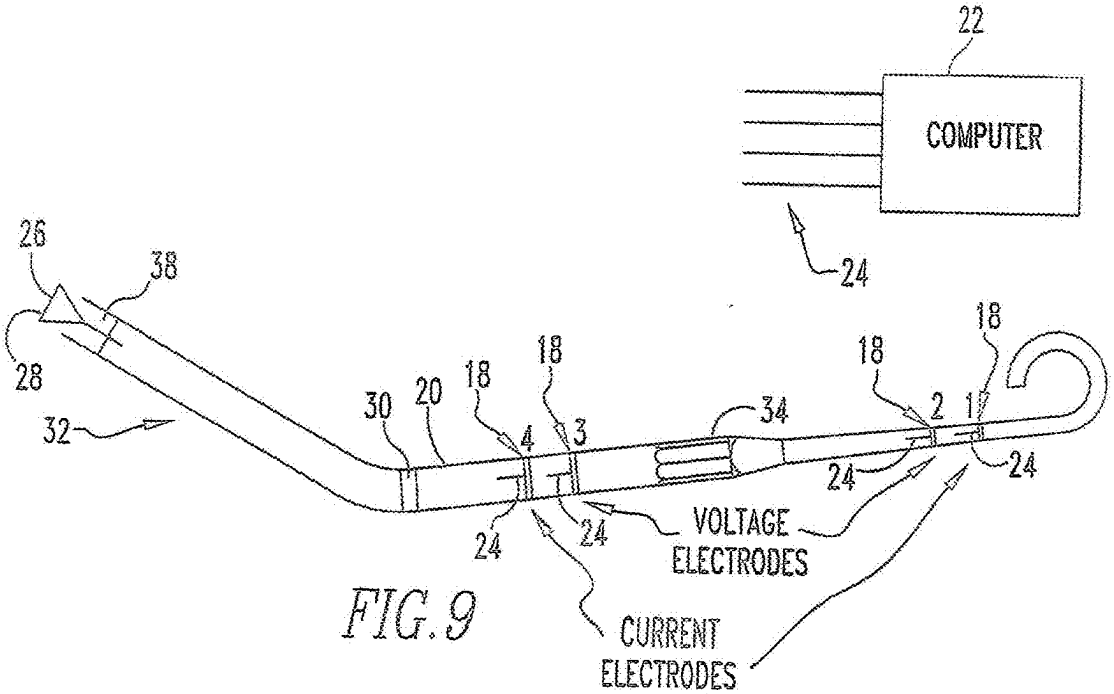

22
COMPUTER
24
26
38
28
32
30
20
18
4
3
34
2
1
VOLTAGE ELECTRODES
CURRENT ELECTRODES

FIG.9

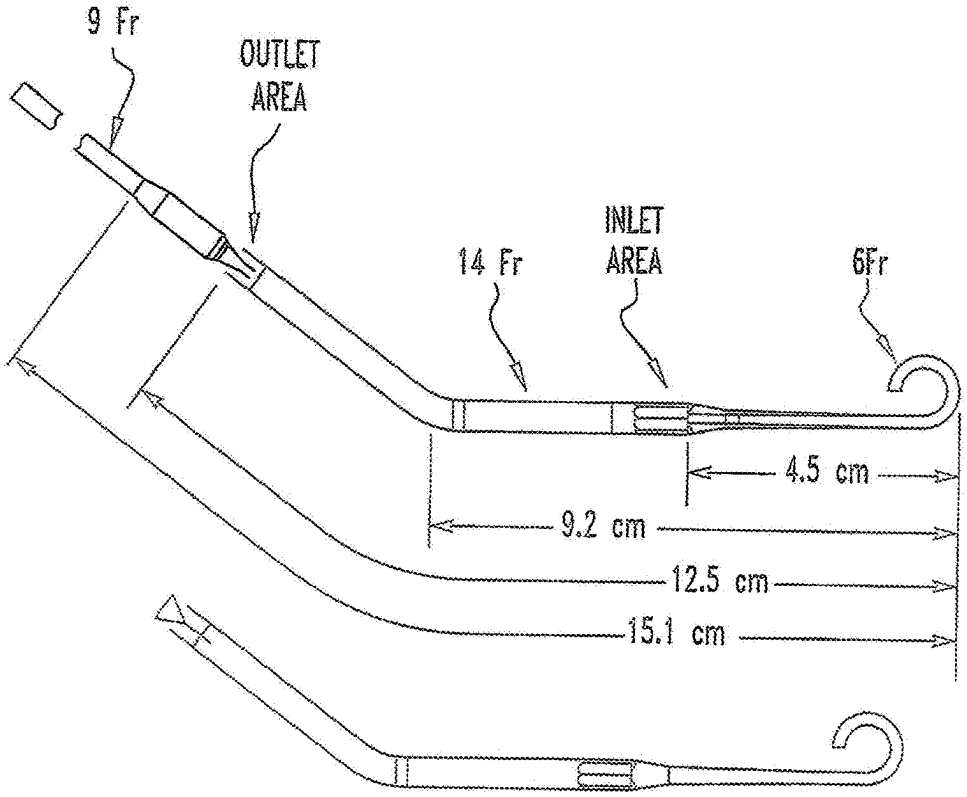

9 Fr
OUTLET AREA
14 Fr
INLET AREA
6Fr
4.5 cm
9.2 cm
12.5 cm
15.1 cm

FIG.10

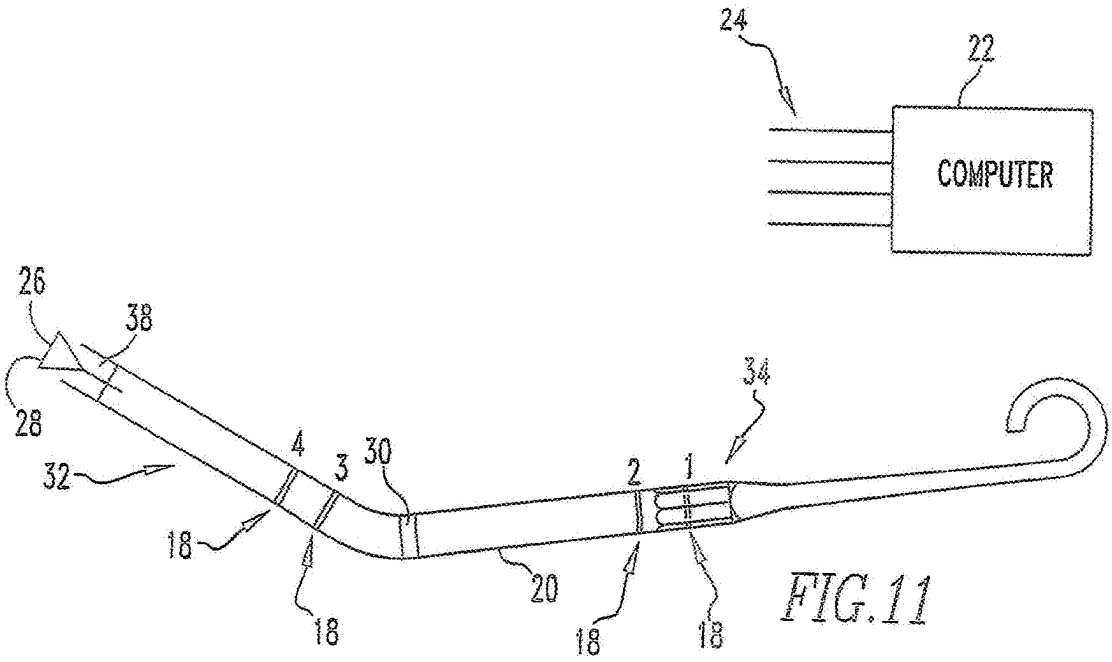

24
22
COMPUTER
26
38
28
32
4
3
30
18
18
20
2
1
34
18
18

FIG.11

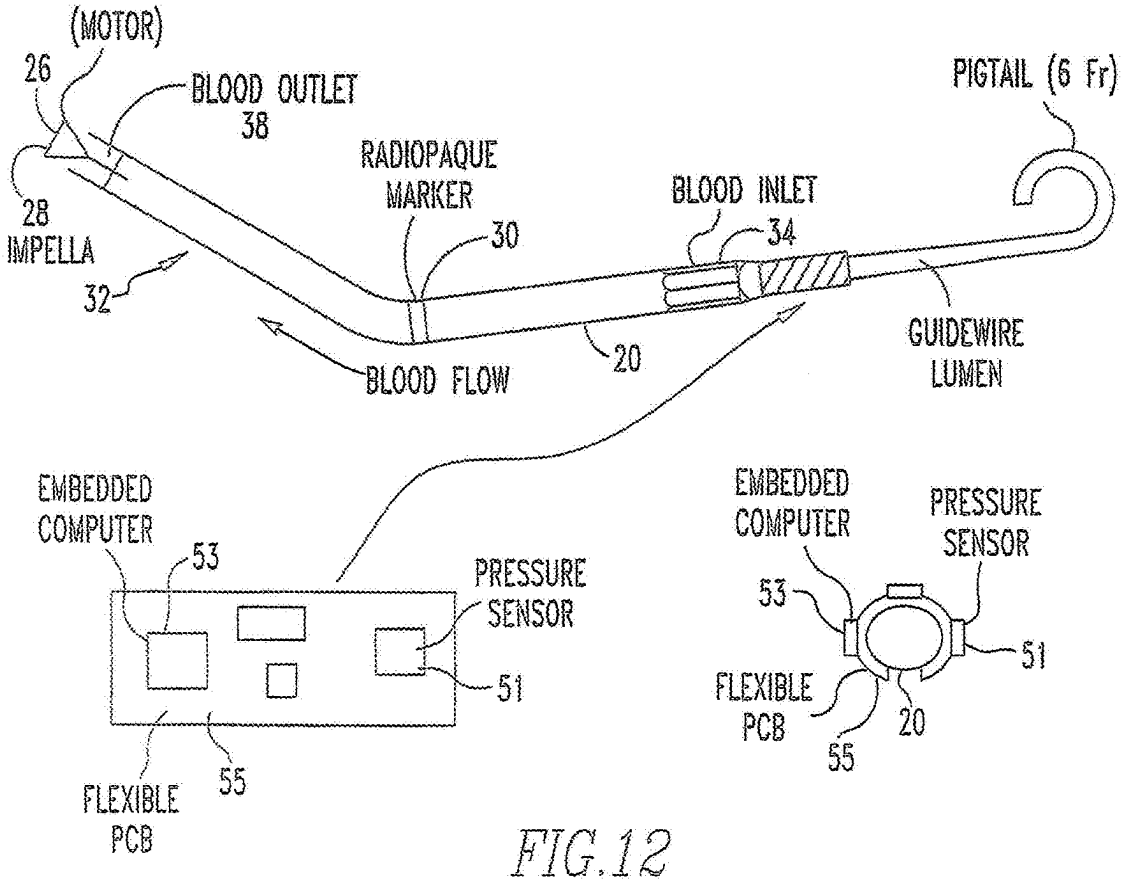

(MOTOR)
26
BLOOD OUTLET
38
PIGTAIL (6 Fr)
RADIOPAQUE
MARKER
BLOOD INLET
28
IMPELLA
30
34
32
GUIDEWIRE
LUMEN
BLOOD FLOW
20
EMBEDDED
COMPUTER
53
PRESSURE
SENSOR
51
FLEXIBLE
PCB
55
EMBEDDED
COMPUTER
PRESSURE
SENSOR
53
51
FLEXIBLE
PCB
20
55

FIG.12

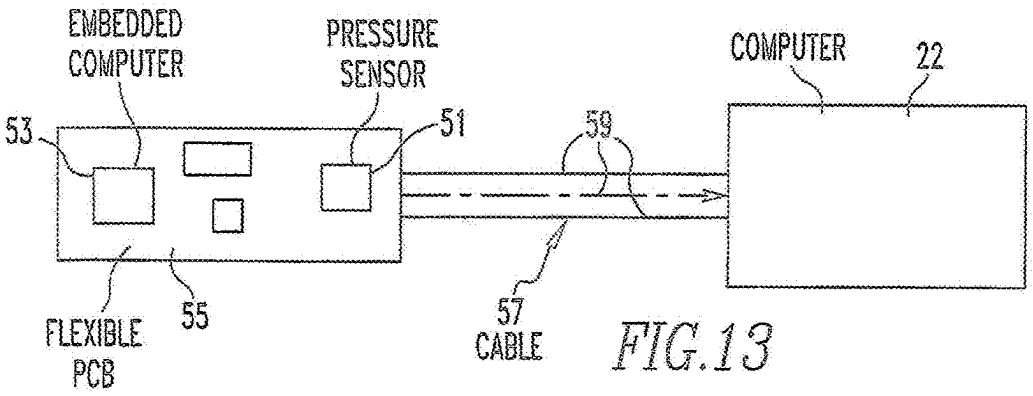

EMBEDDED
COMPUTER
PRESSURE
SENSOR
COMPUTER
22
53
51
59
FLEXIBLE
PCB
55
57
CABLE

FIG.13

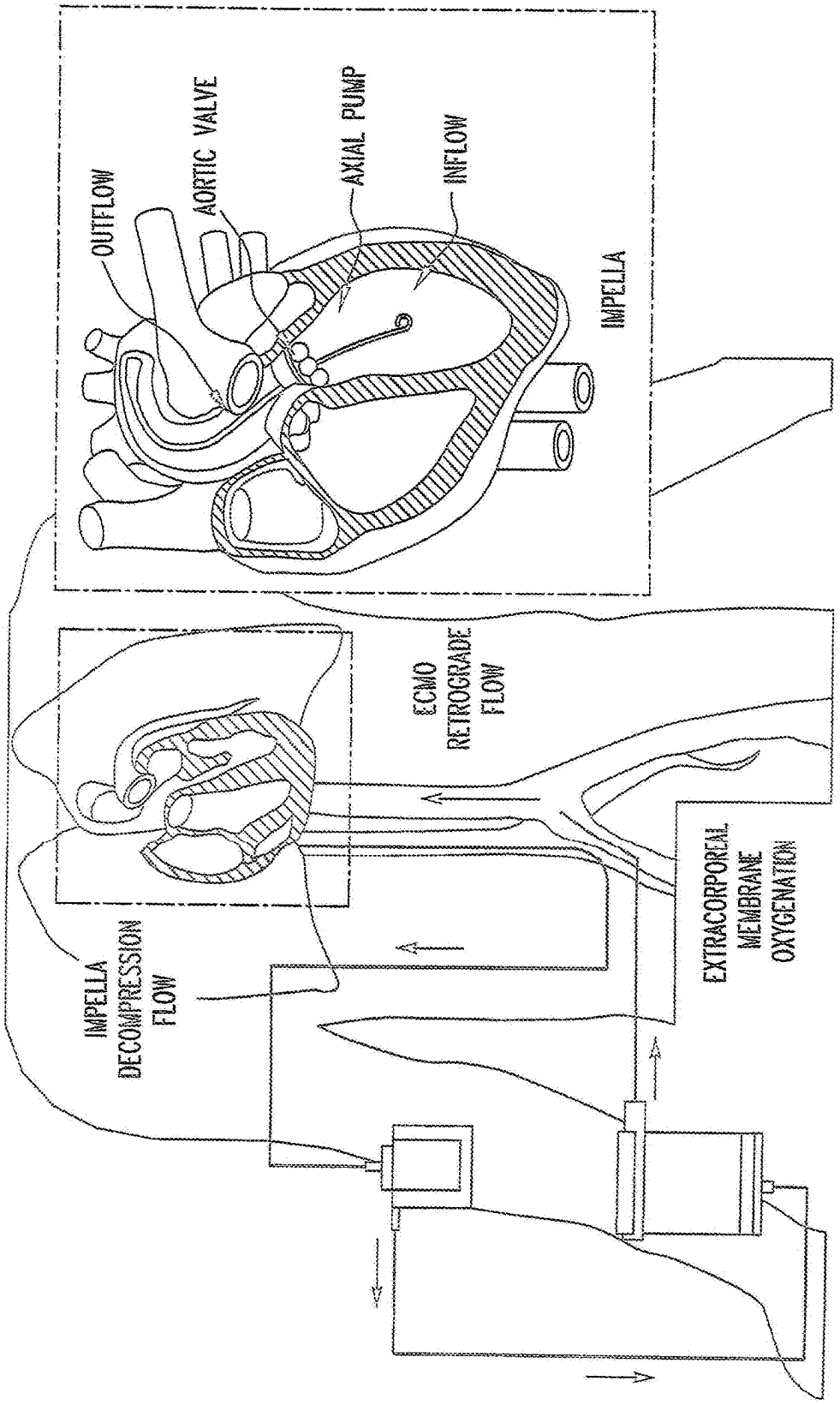

OUTFLOW
AORTIC VALVE
AXIAL PUMP
INFLOW
IMPELLA
ECMO
RETROGRADE
FLOW
IMPELLA
DECOMPRESSION
FLOW
EXTRACORPOREAL
MEMBRANE
OXYGENATION

FIG. 14

METHOD AND APPARATUS FOR ASSISTING A HEART

CROSS-REFERENCE TO RELATED APPLICATIONS

[0001] This is a divisional of U.S. patent application Ser. No. 17/407,138 filed Aug. 19, 2021, now U.S. Pat. No. 12,290,675, which is a continuation-in-part of U.S. patent application Ser. No. 17/238,167 filed Apr. 22, 2021, now U.S. Pat. No. 11,918,799 issued Mar. 5, 2024, all of which are incorporated by reference herein.

FIELD OF THE INVENTION

[0002] The present invention is related to measuring native volume of a heart of a patient having a cardiac assist device. Volume per time is flow, and typically defined as cardiac output (CO). The term, Native Flow, is not a standard term, but describes the output of blood from the native heart as distinguished from a cardiac assist device. The total flow is measured which is a combination of the flow of the pump and the flow of the native heart. These types of flow cannot be distinguished from one another.

[0003] The Native Cardiac Output is Native Volume times heart rate. In a patient without a cardiac assist device, Native CO is equal to total CO, and native volume is equal to stroke volume. However, in a patient with a pump, total CO=native CO+pump CO. (As used herein, references to the "present invention" or "invention" relate to exemplary embodiments and not necessarily to every embodiment encompassed by the appended claims.) More specifically, the present invention is related to monitoring a heart of a patient having a cardiac assist device with admittance or impedance. Furthermore, when two artificial pumps are used together to assist the heart of a patient, knowledge of the native heart stroke volume (SV) or CO (=SV x heart rate) in an instantaneous fashion allows the two artificial pumps to be tuned to allow the native heart to maximize its output in the most efficient mechanical fashion, allowing the native heart to simultaneously rest and heal.

BACKGROUND OF THE INVENTION

[0004] This section is intended to introduce the reader to various aspects of the art that may be related to various aspects of the present invention. The following discussion is intended to provide information to facilitate a better understanding of the present invention. Accordingly, it should be understood that statements in the following discussion are to be read in this light, and not as admissions of prior art.

[0005] Cardiomyopathy is a disease of the heart muscle that can lead to cardiogenic shock, a life-threatening condition in which the heart is unable to pump enough blood to support the body's vital organs. In the U.S. alone, cardiomyopathy causes 1.8 million hospitalizations per year and carries a 30% one-year mortality rate after hospital admission (3). Cardiomyopathy has annual Medicare costs of approximately $20 billion (4) and is the number one cause of hospitalizations and length of stay in patients greater than 65 years old (5). The other cause of cardiogenic shock is acute myocardial infarction complicated by shock. The incidence of cardiogenic shock is increasing, with a >2× increase in the number of cardiomyopathy discharges complicated by cardiogenic shock, from 2004-2014 (6). Cardiogenic shock occurs because the weakened heart cannot pump enough blood to the rest of the body to sustain it. In these cases, a short-term mechanical circulatory support (MCS) device can be placed in the heart to help maintain high forward blood flow while resting (mechanically unloading) the failing heart. These MCS devices are pumps that continuously draw blood from the left ventricle through an inlet port and expel the blood into the ascending aorta, or draw blood from the left atrium or femoral vein and expel in the aorta. The MCS can be inserted via a standard catheterization procedure through the femoral artery, into the ascending aorta, across the aortic valve, and into the left ventricle (FIG. **1**). Or, it can be placed from the femoral vein into the right atrium and via a transeptal catheterization into the left atrium, or via the femoral vein into the inferior vena cava. Once proper placement has been confirmed, the speed of the pump is set depending upon patient condition.

[0006] The ability of MCS devices to maintain peripheral perfusion while mechanically unloading the heart has the potential to improve mortality across at least two large groups of patients (**7**): 1. acute myocardial infarction (MI) with or without cardiogenic shock, and 2. acute decompensated heart failure.

[0007] MCS devices are implanted for up to 6 days (FDA approval) or longer as a bridge-to-recovery or bridge-to-decision for a more long-term ventricular assist implant. In these patients, indwelling time is longer, and bridging to recovery is not guaranteed.

[0008] This is a vast improvement over current practice, whereby a static pump flow is set for the MCS at implant and does not change until the physician decides to initiate the judgement-based and arduous device removal weaning process. There are several risks to the patient in prolonging the initiation of this device removal process including longer recovery time and sepsis.

[0009] The use of bedside ECMO has increased dramatically in the ICU in recent years and especially due to the COVID-19 pandemic. Veno-arterial ECMO (VA-ECMO) is used to perform the function of the heart and lungs during cardiogenic shock and cardiac arrest, pumping a large amount of blood (up to 7 L/min). During VA-ECMO, blood is drained from the venous system, circulated outside the body through an oxygenator, and pumped directly into the femoral artery or ascending aorta. The flow must be set high enough to provide perfusion pressure to the whole body and in particular the brain and heart, which require high pressures in the aortic arch often at a higher flow than simpler instruments like a percutaneous Ventricular Assist Device (pVAD) can provide alone (3-5 L/min). By design, VA-ECMO devices create retrograde flow, which overloads and afterloads the pumping chamber (LV) as blood flows backward from the ECMO entry (femoral artery and ascending aorta) towards the LV. This is known to cause increased pressures and volume inside the left ventricle, hampering myocardial recovery. To correct this overload, the LV must be decompressed or vented by placing both a VA-ECMO device and an Impella pVAD together, called "ECpella".

[0010] Patients fare better with ECpella than they do with VA-ECMO alone, with retrospective studies indicating a significantly lower mortality rate, but there is still much room for improvement. Active unloading with a pVAD provides further benefits, including enabling transition from ECMO to an active cardiac support mechanism (pVAD) with a lower mortality rate. Due to many complications associated with prolonged VA-ECMO (bleeding, thrombo-

sis, limb ischemia, and infection), arguably the most important task after initiation of ECMO is weaning. However, accelerating a weaning protocol is still considered risky and lacks clear clinical consensus, leading directly to ECMO morbidity from prolonged usage.

[0011] Cardiogenic Shock (CS) occurs because the weakened heart cannot pump enough blood to the rest of the body to sustain organ function. In these cases, a short-term mechanical circulatory support (MCS) device can be placed in the heart to help maintain high forward blood flow while resting (mechanically unloading) the failing heart. CS is most commonly caused by acute myocardial infarction (heart attack, MI) with subsequent cardiomyopathy, or long-standing cardiomyopathy with decompensation, and is associated with a 40-50% in-hospital mortality rate.

[0012] Mechanical Cardiac Support (MCS) devices are often initiated with the intent of correcting CS with both hypotension (low blood pressures) and hypoperfusion (low blood flow). MCS devices directly increase forward flow and pressure by pumping blood (and in some cases also oxygenating it), thereby replacing the function of the heart and lungs with a mechanical device. Examples of these MCS devices are percutaneous Ventricular Assist Devices (pVADs) like the Impella suite (Abiomed, Danvers, MA), which pumps blood from the LV to the Ascending Aorta, Intra-Aortic Balloon Pump, and extracorporeal membrane oxygenation, or ECMO.

[0013] ECMO is a type of MCS for severe cardiac or pulmonary failure that is potentially reversible, but poorly or unresponsive to standard clinical management. VA-ECMO is required when left ventricular or bi-ventricular support is necessary due to pump failure, often due to damage done to the myocardial tissue during Acute MI or progression of a cardiomyopathy. In VA-ECMO, blood is drained from the vascular system via the right atrium or inferior vena cava, circulated through an oxygenator outside the body by a mechanical pump, and reinfused into the circulation through the femoral artery into the ascending aorta. This complete bypass of the cardiorespiratory system means that patients are completely dependent on VA-ECMO for respiratory and hemodynamic support, but is limited by loading the myocardium impairing recover and heal from the initial injury. The major steps of VA-ECMO are initiation, titration of flow, maintenance flow, and weaning. Titration is required because flow must be set high enough to maintain perfusion pressure for the whole body (in particular the brain and heart), which require high pressures in the aortic arch. By design, VA-ECMO devices therefore create retrograde flow, which overloads the systemic pumping chamber (LV) as blood flows backward from the ECMO entry (femoral artery and ascending aorta) towards the aortic arch and LV. This is known to cause increased pressure and volume inside the ventricle, hampering myocardial recovery. To correct for this excessive loading, the LV must be decompressed via venting.

[0014] Decompression of the LV is achieved either by passive techniques like intra-aortic balloon pump (IABP), atrial septostomy, and surgical ventricular shunting, or by an active technique using a percutaneous ventricular assist device like the Impella. This decompression is necessary in every patient that receives VA-ECMO, but in addition, rapid left ventricular decompression is essential to avoid pulmonary hemorrhage if left ventricular ejection cannot be maintained using passive techniques, leading to a distinct advantage for a percutaneous ventricular assist device like the Impella (Abiomed, Danvers, MA). Use of the VA-ECMO with Impella for decompression (the so-called "ECpella" technique in the US, and "ECMella" in Europe) has become extremely popular to help with active decompression of the left ventricle. This is accomplished by pumping blood actively from the LV to the Aorta using the percutaneous device.

[0015] Intra-Aortic Ballon Pump (IABP) is a passive decompression technique that uses a balloon in the descending aorta that inflates when the ventricle is filling, and rapidly deflates when the ventricle ejects blood. While some clinicians still use this technique to decompress the left ventricle, due to recent trials it is not recommended as a primary decompression technique.

[0016] The most convincing arguments against the use of IABP include a randomized clinical trial (IABP-SHOCK II), which enrolled 600 patients with CS complicating acute MI randomly assigned to receive IABP, or no IABP. All patients were expected to undergo early revascularization and receive the best medical care, but there was no significant difference in mortality at 30 days, 12 months, or 6.2 years. A 2015 meta-analysis of seven studies (n=790), including IABP-SHOCK came to similar conclusions. For these reasons, the use of active unloading has gained significant traction in recent years, and is still gaining in popularity not only because of the level of control over hemodynamics, but the obvious benefit of weaning a patient off of VA-ECMO quicker to a different active pump solution.

[0017] The Impella device is a pump that continuously draws blood from the left ventricle through an inlet port and expels it into the ascending aorta. It can be inserted via a standard catheterization procedure through the femoral artery, into the ascending aorta, across the aortic valve, and into the left ventricle (FIG. **2**). Once proper placement has been confirmed, the speed of the pump is set depending upon patient's condition. In the ECpella combo, during titration and maintenance of ECMO, the Impella is operated at lower flows (1-2 L/min) than typical for support (up to 3-5 L/min) because it is primarily functioning to decompress or vent the LV. During weaning from ECMO, the Impella can be used for its obvious benefit as a safer MCS device that still provides forward flow from the weakened heart. ECMO can therefore be used as "a bridge to" a bridge-to-recovery (Impella).

[0018] Left Ventricular Monitoring During ECMO weaning is of critical importance because weaning is dependent on recovery of cardiac function, but native left ventricular output may worsen at any time. The cause is usually multifactorial, including the underlying left ventricular dysfunction and insufficient unloading of the distended left ventricle due to both ECMO-induced elevated LV afterload and fluctuations in blood flow into the left ventricle from the pulmonary circulation and right ventricle caused by weaning. Heretofore, there has been no adequate real-time native left ventricular volume measurement in existence for this extremely important measurement. Surrogates are most often used for real time LV volumetric information include using pressure (arterial line pulsatility), Pulmonary Arterial Catheter (PAC), or echocardiography (Echo) frequency every 8-24 hours but not real-time. All three have major drawbacks when used to make weaning decisions. Arterial line pressure pulsatility is primarily used because of its availability and ease. It is not quantitative, and pressure is

also not a surrogate for volume. Additionally, the small pressure signal from the native heart output is swamped by the operation of the ECMO (and further complicated by the Impella). Echo suffers because it is resource intensive, despite still being an instantaneous measurement. Resources required include an echocardiographer, an echo machine, and echo data storage to compare previous echoes. Echo is therefore simply not frequently available or fast enough to be relied upon. PAC use in CS patients with or without MCS has not been proven to save lives, and experts have widely differing views on the utility of the measurement.

[0019] Weaning protocols for ECMO vary widely from center to center, based on experience, and resources. It is well known that shortening time on ECMO decreases the risk of complications like bleeding, thrombosis leading to stroke, infection, seizures and limb ischemia, but accelerating weaning protocols is still considered risky and lacks consensus. Most protocols therefore wean over days of time, ensuring patient hemodynamic stability over multiple decreasing ECMO flows for periods of at least 24 hours at each flow. What is needed is an adequate, accurate, reproducible real-time left ventricular volume measurement.

BRIEF SUMMARY OF THE INVENTION

[0020] The present invention pertains to an apparatus for a heart of a patient. The apparatus comprises a cardiac assist device adapted to be implanted into the patient to assist the heart with pumping blood. The apparatus comprises one or more sensors adapted to be implanted into the patient. The sensor(s) in communication with the cardiac assist device and the heart which measures native volume of the left heart. The apparatus may be used in a patient to measure left ventricular recovery and titrate the relative dependence of both Impella and ECMO as they are started, and as they are weaned.

[0021] The present invention pertains to an apparatus for a heart of a patient. The apparatus comprises a cardiac assist device adapted to be implanted into the patient to assist the heart with pumping blood. The apparatus comprises one or more sensors adapted to be implanted into the patient. The sensor(s) in communication with the cardiac assist device and the native heart which monitors the heart based on admittance while the cardiac assist device is in operation. The sensor(s) in communication with two cardiac assist devices and the native heart which monitors the heart based on admittance while the cardiac assist devices are in operation.

[0022] The present invention pertains to an apparatus for a native heart of a patient. The apparatus comprises a first cardiac assist device and a second cardiac assist device which is adapted to be implanted into the patient to assist the heart with pumping blood and resting to recovery. The apparatus comprises one or more sensors adapted to be implanted into the patient to monitor the impact and tune either one or both of the cardiac assist devices simultaneously to synchronize their activities to allow the heart to pump and recover. The sensor(s) in communication with the cardiac assist device and the heart which monitors the heart based on impedance while the first and second cardiac assist devices are in operation.

[0023] The present invention pertains to a method for treating a heart of a patient. The method comprises the steps of pumping blood of the patient with one and/or two cardiac assist devices implanted into the patient. There is the step of measuring native volume and stroke volume of the native heart with one or more sensors implanted into the patient, the sensor(s) in communication with the cardiac assist device and/or devices of the heart.

[0024] The present invention pertains to apparatus for a heart of a patient. The apparatus comprises a cardiac assist device and/or devices adapted to be implanted into the patient to assist the heart with pumping blood. The apparatus comprises one or more sensors adapted to be implanted into the patient. The sensor(s) producing a source signal. The sensor(s) in communication with the cardiac assist device and/or devices and the heart which monitors the heart with the source signal. The sensor dynamically shifting the source signal to avoid noise from the pump or other sources.

[0025] The present invention pertains to a method for assisting a heart of a patient. The method comprises the steps of producing a source signal by one or more sensors implanted in the patient. The sensor(s) in communication with a cardiac assist device and/or devices implanted into the patient to assist the heart with pumping blood and the heart and resting the heart for recovery. There is the step of monitoring the heart by the sensor with the source signal. There is the step of the sensor dynamically shifting the source signal to avoid noise from the pump or the pumps or other sources.

[0026] The present invention optimizes the weaning process for patients in cardiogenic shock or cardiac arrest that are being treated with extracorporeal membrane oxygenation (ECMO) in an intensive care unit (ICU) setting. This advancement is designed to reduce the extremely high mortality of patients on ECMO (~50%).

[0027] The present invention pertains to an apparatus for a heart of a patient. The apparatus comprises a first cardiac assist device adapted to be implanted into the patient to assist the heart with pumping blood which increases load on the heart. The apparatus comprises a second cardiac assist device adapted to be implanted into the patient to offload the heart or vent the heart simultaneously with the first cardiac assist device, which assists the heart with pumping blood. The first cardiac assist device and the second cardiac assist device tuned to maximize blood flow to the body of the patient, while resting the heart so the heart may recover function.

[0028] The present invention pertains to a method for treating a heart of a patient. The method comprises the steps of assisting the pumping of blood from the heart with a first cardiac assist device implanted into the patient which increases load on the heart and a second cardiac assist device implanted in the heart which vents the heart simultaneously with the first cardiac assist device. There is the step of obtaining diagnostic information about the heart as a function of native cardiac output (CO) or SW from LV PV loops from an implanted sensor in communication with the heart while the implanted first and second cardiac assist devices are in operation in the patient assisting the pumping of blood in the patient. There is the step of tuning the first cardiac assist device and the second cardiac assist device to maximize blood flow to the body of the patient, while resting the heart so the heart may recover function.

BRIEF DESCRIPTION OF THE SEVERAL VIEWS OF THE DRAWING

[0029] In the accompanying drawings, the preferred embodiment of the invention and preferred methods of practicing the invention are illustrated in which:

[0030] FIG. **1** shows the claimed invention in conjunction with the heart.

[0031] FIG. **2** is a block diagram of the claimed invention.

[0032] FIG. **3** shows the claimed invention.

[0033] FIG. **4** shows the cardiac assist device and electrodes in conjunction with the heart.

[0034] FIG. **5** shows a graph of frequency versus signal strength in regard to a simulated admittance measurement in a water bath with an Impella CP at minimum speed of 23,000 RPM.

[0035] FIG. **6***a* shows an unmodified Impella device.

[0036] FIG. **6***b* shows a modified silver tape Impella device with electrodes.

[0037] FIG. **6***c* shows a modified stainless steel Impella device with four electrodes.

[0038] FIG. **7** shows a Fourier analysis of motor electromagnetic noise versus admittance signal for all 9 motor speeds.

[0039] FIG. **8** shows in vitro testing with motor at various levels showing low noise.

[0040] FIG. **9** shows the claimed invention.

[0041] FIG. **10** shows the claimed invention.

[0042] FIG. **11** shows the claimed invention with alternative placement of the electrodes.

[0043] FIG. **12** shows a flexible printed circuit board wrapped around the catheter.

[0044] FIG. **13** shows the embedded system is interfaced to the main computer with a cable.

[0045] FIG. **14** shows the ECpella of the present invention

DETAILED DESCRIPTION OF THE INVENTION

[0046] Referring now to the drawings wherein like reference numerals refer to similar or identical parts throughout the several views, and more specifically to FIGS. **1**, **2** and **3** thereof, there is shown an apparatus **10** for a heart **12** of a patient. The apparatus **10** comprises a cardiac assist device **14** adapted to be implanted into the patient to assist the heart **12** with pumping blood. The apparatus **10** comprises one or more sensors **16** adapted to be implanted into the patient. The sensor(s) **16** in communication with the cardiac assist device **14** and the heart **12** which measures native volume, stroke volume and pressure of the heart **12**. The apparatus **10** may be used with a patient during recovery or in high-risk percutaneous coronary intervention.

[0047] The sensor **16** may include electrodes **18** directly attached to the cardiac assist device **14** that produce signals which are used to measure the native volume, stroke volume and pressure of the heart **12**. The cardiac assist device **14** may have a shaft **20** that is adapted to be positioned in the heart **12**, and the electrodes **18** are in contact with the shaft **20** that is positioned in the heart **12** chamber. The electrodes **18** should be in the chamber of interest for the sensor **16** to work properly. If the electrodes **18** are not in the chamber of interest, the sensor **16** most likely will not work.

[0048] The sensor **16** may include a computer **22** for data acquisition and analysis of the signals. The computer **22** is in communication with the electrodes **18**. The computer **22** may provide electrical currents to the electrodes **18** and may measure corresponding voltages to make admittance-based measurements and analyze the admittance-based measurements to make real-time volume, stroke volume and pressure measurements of the heart **12**. The sensor **16** may include wiring **24** that is in direct contact with the electrodes **18** and which extends to the computer **22** over which the electrical currents pass creating the corresponding voltages. There may be a pressure sensor **51** adapted to be implanted into the patient. The pressure sensor **51** in communication with the cardiac assist device **14** and the heart and the computer **22** which monitors the left ventricular pressure while the cardiac assist device **14** is in operation. In addition, the pressure sensor with the computer may plot native pressure volume loops while the cardiac assist device is in operation, for instance, to measure the work done by the heart and its efficiency. A considerable amount of information on cardiac performance can be determined from the pressure vs. volume plots.

[0049] The cardiac assist device **14** may include a motor **26** and an Impella **28** disposed in the shaft **20** which is driven by the motor **26** to assist the heart **12** with pumping blood. The cardiac assist device **14** may have a marker **30** to guide proper placement of the cardiac assist device **14** in the heart **12**. The electrodes **18** may be disposed on the shaft **20** of the device. Alternatively, the apparatus **10** may include a catheter having a shaft **20** disposed alongside the shaft **20** of the device and the electrodes **18** may be disposed alongside the shaft **20**.

[0050] The cardiac assist device **14** may be a temporary mechanical circulatory support (MCS) device which is a catheter-mounted blood pump that draws blood from a left ventricle of the heart **12** through an inlet port **34** of the MCS **32** and expels blood into an ascending aorta **36** of the heart **12**, thereby reducing some of the mechanical load on the heart **12** and promoting recovery. The pump may draw the blood intermittently in a pulsatile manner that mimics the natural pulsatile movement of the heart **12** or the pump may draw the blood from the left ventricle continuously. If the pump draws the blood intermittently, the timing of the intermittent action and the pulsing of the pump blood may be coordinated with the pumping motion of the heart **12**. The native cardiac output (CO) and pressure measurements by the sensor **16** may provide a feedback signal to the MCS **32** to modulate flow/volume by the MCS **32** during treatment.

[0051] In contrast to having utility for weaning and treatment in a temporary MCS device that is catheter-mounted and connected to a main powered external controller, a permanent implant battery-powered MCS device (often used for bridge-to-transplant rather than bridge-to-recovery), would benefit from a feedback signal to control pump speed in different scenarios. These include battery management, demand feedback, and long-term dysfunction diagnosis, for example, battery management is important in implanted devices, whether rechargeable or not, because patient's quality of life is typically tied to how unobtrusive the device is to the activities of everyday living. In general, the faster the pump flow, the more power is necessary to produce that flow. Total flow is the important metric to sustain in patients with an implantable MCS device, so having a high pump flow when the native output is normal unnecessarily wastes battery life, directly leading to lower quality of life.

[0052] Demand feedback is typically unimportant in temporary MCS scenarios, because they are typically indicated for rescue, or high-risk situations (like high-risk PCI). In these emergent and elective situations, the pump flow is typically set for as high as the patient will tolerate, because larger total flow for short periods is protective, while total flow that is slightly low can be extremely detrimental due to concomitant conditions. In long-term implant scenarios, the

patient will exhibit a larger range of possible flow demand, for example, when exercising, for which a higher-than-normal pump flow is necessary. Other devices like demand pacers (https://www.biotronik.com/en-us/products/services/cls) measure and respond to this demand by using end systolic volume (the minimum volume sensed) as a surrogate for contractility, which is a marker for blood flow demand. This technique of demand measurement has the advantage of not being tied directly to activity, which could easily be measured using accelerometers. One example of non-activity related demand is changing pump flow to meet the demands on the body created by intense emotion (anger typically requires higher blood flows, and also increases contractility on a beat-to-beat basis, for example). Demand pacers can increase cardiac output by increasing heart rate, but a long term MCS device could directly modulate higher blood flow (stroke volume) instead.

[0053] Long-term dysfunction due to remodeling changes in the heart (usually marked by an increase in end-systolic and end-diastolic volume over time) are too long of a time scale to matter in temporary MCS devices. However, in completely implanted MCS devices, the native heart measurement can be used to detect worsening (or improving) heart failure status purely as a diagnostic. Further, this information can be used to tune a single or two simultaneous devices so their actions are coordinated and in the best interests of the patient for both temporary and long-term support, as well as weaning.

[0054] The present invention pertains to an apparatus **10** for a heart **12** of a patient. The apparatus **10** comprises a cardiac assist device **14** adapted to be implanted into the patient to assist the heart **12** with pumping blood. The apparatus **10** comprises one or more sensors **16** adapted to be implanted into the patient. The sensor(s) **16** in communication with the cardiac assist device **14** and the heart **12** which monitors the heart **12** based on admittance while the cardiac assist device **14** is in operation.

[0055] The present invention pertains to an apparatus **10** for a heart **12** of a patient. The apparatus **10** comprises a cardiac assist device **14** adapted to be implanted into the patient to assist the heart **12** with pumping blood. The apparatus **10** comprises one or more sensors **16** adapted to be implanted into the patient. The sensor(s) **16** in communication with the cardiac assist device **14** and the heart **12** which monitors the heart **12** based on impedance while the cardiac assist device **14** is in operation.

[0056] The present invention pertains to a method for treating a heart **12** of a patient. The method comprises the steps of pumping blood of the patient with a cardiac assist device **14** implanted into the patient. There is the step of measuring native volume of the heart with one or more sensors **16** implanted into the patient. The sensor(s) **16** in communication with the cardiac assist device **14** and the heart **12**. The method can also, or alternatively, use the sensor **16** and the cardiac assist device in the various embodiments described herein.

[0057] In the operation of the invention, a temporary MCS **32** device is a catheter-mounted blood pump, typically placed for less than 7 days in patients with cardiomyopathy and cardiogenic shock, heart attack and shock, or high-risk PCI and shock, that continuously draws blood from the left ventricle through an inlet port **34** of the MCS **32** and expels the blood into the ascending aorta **36**, thereby reducing some of the mechanical load on the heart **12** and promoting recovery (hemodynamic support). An MCS **32** is unlike other more permanently placed pumping devices, because it is placed in the patient using a standard catheterization procedure (without piercing the heart **12**). This technique is preferable for use as a bridge-to-recovery, because it can be easily removed. Once proper placement has been confirmed, the speed of the pump is set depending upon patient condition on a case-by-case basis, and treatment is deemed complete once the heart **12** has recovered and hemodynamics have returned to normal.

[0058] Initiating the device removal weaning process is based upon numerous factors, most importantly Cardiac Power Output (CPO= [CO*Mean Arterial Pressure]/451). During continuous use of an MCS **32** device, the total CO to the body comes from two components: total CO= "native CO"+ "device CO". "Native CO" is the amount of blood ejected from the ventricle by the recovering heart **12**, and "device CO" is the amount of blood pumped by the MCS **32** device, and/or simultaneous two devices. Over time, the native CO from the heart **12** naturally rises, as it recovers slowly from decreased load, signaling improvement. Removal of the MCS **32** device requires "weaning" the patient from pump support by reducing pump speeds prior to removal. Optimal MCS **32** use would require reducing pump speed over an extended time as the native CO reaches near-normal levels, but in practice native CO is never measured during recovery, because it is clinically impractical to continuously measure CO using echocardiograms during the entire recovery period (could be days).

[0059] Ideally, an MCS **32** device would continuously measure real-time native CO, and then automatically adjust the pump speed to modify the device CO, while maintaining an overall total CO. This method would naturally wean the patient as he/she heart recovers as the native CO rises. The physician could monitor the native CO measurement and remove the MCS **32** device when appropriate. In Phase I, BSM proved that accurate measurements of real-time native CO are possible using an admittance-based Impella prototype ("Impella-CO") while operating within electromechanical pump noise. This was designed and demonstrated both on the bench, and in an animal model showing excellent agreement with multiple CO standards.

[0060] Admittance measurement is blocked by electrical insulators like the pump body (made of plastics). It can only tell what the volume of the outside blood pool is, because the measurement relies on the flow of electricity being "admitted." Total CO is very easy to measure, and can be done using a number of different methods (Fick, Thermodilution, Indocyanine Green, Flow Probe, etc.). Native CO of the left ventricle can only be determined by imaging methods (directly visualizing the size of the pumping chamber, the LV, such as echocardiography, and MRI), and Admittance. As shown in FIGS. **1** and **4**, the outlet port **38** of the device is in the ascending aorta **36**, outside of and downstream from the chamber of the heart **12**. In this way, blood from the outlet port **38** mixes with the native output of blood from the heart **12**, downstream of where blood pumped solely by the heart **12** leaves the heart **12**, so only the Native CO is measured by admittance. The blood inside the device is not measured because the pump body is made of plastic and shields the blood in the pump from being measured.

[0061] The pump typically does not directly measure the amount of blood flow going through it, and can only estimate its own flow (not measure it directly) by using the

power delivered to/consumed by the pump as a surrogate for how hard the pump is working to pump blood (assuming the inlet and outlet remain the same, and the pump speed is proportional to CO).

[0062] Native Cardiac Output is the amount of forward blood flow that is due to the pumping action of the heart **12**. To clarify, when there is no pump present, Cardiac Output is equal to Native Cardiac Output. When there is a pump present, the pump flow (the flow of blood through the pump) in L/min is the pump output. Then, the total Cardiac Output is equal to the pump flow plus the Native Cardiac Output. Total CO=Pump CO+Native CO.

[0063] Cardiomyopathy is a disease of the heart **12** muscle that can lead to cardiogenic shock, a life-threatening condition in which the heart **12** is unable to pump enough blood to support the body's vital organs. In the U.S. alone, cardiomyopathy causes 1.8 million hospitalizations per year and carries a 30% one-year mortality rate after hospital admission (3). Cardiomyopathy has annual Medicare costs of approximately $20 billion (4) and is the number one cause of hospitalizations and length of stay in patients greater than 65 years old (5). The incidence of cardiogenic shock is increasing, with a >2× increase in the number of cardiomyopathy discharges complicated by cardiogenic shock, from 2004-2014 (6). This is particularly true if additional causes of cardiogenic shock such as acute myocardial infarction. Cardiogenic shock occurs because the weakened heart **12** suddenly cannot pump enough blood to the rest of the body to sustain it. In these cases, a short-term mechanical circulatory support (MCS) device can be placed in the heart **12** to help maintain high forward blood flow while resting (mechanically unloading) the failing heart **12**. These MCS **32** devices are pumps that continuously draw blood from the left ventricle through an inlet port **34** and expel the blood into the ascending aorta **36**. The MCS **32** can be inserted via a standard catheterization procedure through the femoral artery, into the ascending aorta **36**, across the aortic valve, and into the left ventricle (FIG. **1**). Once proper placement has been confirmed, the speed of the pump is set depending upon patient condition.

[0064] The ability of MCS **32** devices to maintain peripheral perfusion while mechanically unloading the heart **12** has the potential to improve mortality across at least three large groups of patients (**7**): 1. high risk percutaneous coronary intervention (PCI), 2. acute myocardial infarction (MI) with or without cardiogenic shock, and 3. acute decompensated heart failure.

[0065] While the first category of high-risk PCI is an elective surgery and is typically performed over a surgical (short) period, for the last two categories, MCS **32** devices are implanted for up to 6 days as a bridge-to-recovery or bridge-to-decision for a more long-term ventricular assist implant. In these patients, indwelling time is longer, and bridging to recovery is not guaranteed.

[0066] Preliminary experiments were conducted on test MCS **32** devices provided by Abiomed to determine the initial noise spectrum (FIG. **5**). The noise spectrum of the motor **26** vs. the "signal" (the 20 KHz waveform from CardioVol) was measured over all available pump speeds (0 to 46,000 rpm). It was determined that 1) pump noise is essentially the same regardless of pump speed, but has large spikes at 50, 100, and 150 kHz (this is good because Cardio Vol can operate at any frequency in the 1-100 KHz range, and is currently configured for 20 kHz) and **2**) noise spectrum is dependent on the electrode geometry used (also good, because unlike traditional conductance, admittance utilizes only four electrodes **18** at a time, allowing flexibility in design that allows integration with existing devices like the MCS Impella).

[0067] FIG. **6** shows a black band located between the wiring **24** exit and the most proximal electrode that is radiopaque and used clinically to align with the aortic valve to guide proper placement. This design ensures that the surgeon will place all four electrodes **18** within the left ventricular heart **12** chamber.

[0068] Motor **26** noise quantification: Fourier frequency analysis of the motor **26** noise signal during pump operation was used to determine the optimal frequencies to use for the cardiac volume measurements. Volume calculations using admittance-based techniques allows for real-time measurement of both blood and muscle contributions by taking advantage of the differing electrical properties in the frequency range of interest. Within the frequency band of 1 kHz-100 kHz blood is purely resistive, but myocardium is both resistive and capacitive. Admittance measurements are performed in the complex Fourier plane, which allows measurement and separation of both the capacitive and resistive properties of the volume, allowing a pure measurement of blood volume to be extracted from the total signal. Because the measurement can be made at any frequency in the span, it is possible to pick a frequency that is uncorrupted by a known noise source, like that of the Abiomed Impella motor. As shown in **7**, the excitation current signal used to make the Cardiac Output measurement (FIG. **7**, Signal) is several orders of magnitude larger than the noise floor (FIG. **7**, Noise floor Target). Note that the pump noise can be clearly seen at 50 khz, and at 100 kHz at all 9 pump speeds, and does not overlap with the measurement. It is clear from task **1** that any frequency at least 5 kHz away from DC, and not an integer multiple of 50 kHz could be utilized for the admittance-based volume measurement. 20 kHz is chosen for the prototype design to maximize signal to noise ratio while minimizing power and reducing the complexity of a higher frequency design. FIG. **7**: In vitro testing with Pump at various levels showing low noise. Dynamic testing simulating a "heart beat" by squeezing the sides of a bottle while the pump is at P3, and P6. No filtering has taken place, and the raw admittance (volume) signal is unaffected by motor **26** noise.

[0069] Task **2**: Modify the operating frequency and spatial electrode configuration of an admittance unit for maximum signal to noise ratio using information from task **1**.

[0070] Admittance Unit Design: An instrument to measure admittance derived blood volume was designed to generate a constant amplitude current at an operating frequency of 20 kHz injected into the outer two electrodes **18** prototyped onto the Impella pump, and used to measure the resulting voltage from the inner two electrodes **18** as describe in task **1**. Because the current is constant, the blood volume is proportional to the measured voltage from the inner two electrodes **18**.

[0071] In vitro testing: A bottle of saline with conductivity designed to mimic the conductivity of blood (s=8 mS/cm) was used to determine if the admittance measurement is sensitive to changing volumes in the presence of electrical pump noise, and because the bottle has flexible sides, it is possible to modulate the volume sensed near the Impella pump by repeatedly squeezing the bottle to simulate a

beating heart **12**. In this way, a time-varying signal is displayed on the GUI and recorded to examine signal quality (FIG. **8**). The admittance instrument is shown to be highly responsive to changing volume in the bottle even in the presence of the pump operating at standard flow levels P3 and P6 (there are 9 pump speeds total, in addition to "off", so P3 and P6 represent middle values of speed). Note that when there is no simulated pumping, the motor **26** turning on does not change the value measured by the prototype CardioVol-Impella device, illustrating that the native CO is unaffected by motor **26** noise. The level of change caused by the pump in a stationary setup is less than 1 mΩ (milli-Ohm).

[0072] Signal to Noise Ratio (SNR) measurement: in vitro, SNR measurements are straightforward, and can be calculated using a discrete Fourier transform (DFT) on an oscilloscope, and an ideal signal which is derived from a continuous sine wave. However, in vivo, this measurement is not practical, given the added power required to maintain the continuous sine wave. Instead, a pulsed current excitation waveform is used to make extremely fast impedance measurements at 20 kHz, and calculate a Fast-Fourier Transform (FFT) in real time. This requires a modified SNR measurement approach for accuracy. In general, ReZ and ImZ are used to calculate the volume signal. Therefore, Signal(S) power can be calculated. The noise (T) can be calculated from all of the other bins of frequency in the FFT. In this way, an SNRa which varies from 0 to 1000 (1000 being a "perfect" no noise sine wave, and 0 being a lack of any discernable signal) can be calculated. Values above 900 are considered extremely low noise, and indicate a noise-free measurement in our in vivo measurements. The governing equations are shown below:

$$S = \mathrm{Re}Z^2 + \mathrm{Im}Z^2(V^2) \text{ at } 20 \text{ kHz}$$

$$T = \sum_{non20\,kHz\,bins} Sig - Avg$$

$$SNR_a = 1000 * S/T$$

[0073] Task **3**: Measure native CO using admittance vs. standards in an animal model while simultaneously operating an MCS **32** device (Impella heart pump).

[0074] Goals: The goal for this preclinical evaluation was to measure CO using the admittance instrument connected to a prototype Abiomed Impella Mechanical Circulatory Support device and compare those measurements to standard clinical CO measurement methods. There is currently no universally accepted "gold standard" for CO measurement, and while every method has its weaknesses, our goal was to show good agreement with at least two of the current standards. Good agreement was defined as within-subject coefficient of variation (wCV)<20%, which is the agreement level that two expert echo readers show when reading the same set of echoes. 0% would indicate perfect agreement. wCV is mathematically defined as the standard deviation divided by the mean.

[0075] Protocol: N=3 pigs are instrumented with: 1) the modified Impella pump with CO measurement capability connected to the admittance unit, and 2) independently measured CO using a Swan Ganz catheter in the pulmonary artery capable of measuring 2A) CO via thermodilution continuous cardiac output, or CCO (Edwards Scientific), 2B) CO via bolus instantaneous cardiac output, or ICO (Edwards Scientific) and 2C) CO via myocardial oxygenation (Fick method). CO using 3) echocardiography with the aortic velocity time integral method, or aortic VTI at the level of the aorta are also measured. Measurements of CO were taken before the Impella pump was implanted, after the pump was implanted in the "off" state, and at each of the nine pump speeds (P1, P2, P3, P4, P5, P6, P7, P8, and P9). The protocol was discontinued if there was hemodynamic instability present, indicated by a "suction" alarm from the Impella. In all instances, "native heart" CO was calculated by taking the total CO measurement and subtracting the pump flow. The only exceptions were echo measurements (echo cannot measure the pump flow at the level of the aorta because the pump itself is opaque to sound waves), and admittance (admittance measures only the electrical properties of blood and myocardium outside the Impella because the catheter body is an electrical insulator opaque to electrical waves).

[0076] Results: In all three pigs, agreement with at least one of the standards (wCV≤16%) and in one of the pigs (Animal **2**) were able to be shown, wCV=9% for all 5 standards simultaneously were able to be shown, for all of the Impella pump speeds. Further, while there was no CO change planned in the protocol as a result of changing pump speed, the natural offloading of the heart **12** created by the Impella device shows a lower native CO for each progressively higher pump setting. This real phenomenon indicates not only that the Impella device offloads a failing heart **12** while maintaining forward CO and mean arterial pressure, but that it is possible to make this measurement in real-time using the prototype instrument developed.

[0077] Admittance vs. Conductance—There are three novel concepts that must be utilized to solve the problems preventing an Admittance measurement in situ with a generic noise source like a pump. 1) Traditional conductance catheters (including "dual frequency" devices) cannot determine accurate volumes because they all subtract a single value for parallel conductance. Using admittance-based technology solves these issues using a measurement of the capacitive nature of the myocardium, but both measurements are sensitive to noise from the motor **26**, so frequency of operation must be redesigned. 2) The wires and electronics of an admittance-based catheter must be extremely small so as not to substantially increase the outer diameter of the MCS **32** device, which is 12 French in the case of the Abiomed Impella CP, (Danvers, MA) and 3) Electrode placement must be designed from scratch around the functional elements of the Impella device, which affects the field geometry.

[0078] General Considerations—In general, conductance measurements of volume are made by considering the chamber of interest and creating a custom catheter (a conductance catheter) that spans the area to make the most linear measurement of impedance possible. A measurement of admittance can be adapted for use on an arbitrary catheter, which is advantageous because many instruments are implanted either temporarily (like a percutaneous heart **12** pump or the cardiac assist device **14**, see FIG. **1**) or more permanently (like a cardiac implantable electronic device). These instruments often already have electrodes **18**, microcontrollers, and signal processing that work in concert to achieve a goal like pacing the heart **12**, or supporting a weak heart **12** by increasing forward flow. The adaptation of an

admittance measurement to these existing resources can have diagnostic advantages at low additional cost, by carefully considering design tradeoffs to achieve a goal of low barrier to market entry, or reduction of contaminating noise. In this patent, it is discussed how to flexibly achieve both goals to combine a hemodynamic measurement with an existing heart **12** pump by taking advantage of two main ideas: 1) Working with non-ideal electrode locations, geometries, and inter-electrode spacing to linearize a measurement made in a non-linear region, and 2) using a frequency of measurement that avoids the noise of nearby, known interference.

[0079] Electrode Material-Electrodes **18** should be made of a biocompatible material, that is low resistance, like platinum or gold. The reasoning here is that the electrode itself should contribute as little as possible to the final measurement, making calibration less complicated.

[0080] Electrode Number—It is widely known that the electrode-electrolyte interface impedance that arises from putting a metal electrode in the presence of an electrolyte can change the measured total impedance. To protect against this, typically four electrodes (tetrapolar) 18 are necessary at a minimum, to reduce polarization effects. If numbered from the distal to the proximal end of a catheter as 1 (distal tip), 2, 3, 4 (most proximal electrode), typically electrodes 1 and 4 provide a function of current generation by injecting current, and 2 and 3 are used to measure the voltage arising from the current flowing through the electrolyte. Tetrapolar electrodes provide an advantage, because the design of a good constant current source does not change with electrode resistance change, ensuring that the admittance (current over voltage) does not change with fouling of electrodes **1** or **4**.

[0081] Fouling is a change in resistivity that occurs due to a local change in the resistance of the electrode. Typically, this is caused by scar tissue formation, oxidation, or other change in the electrode/electrolyte impedance on the voltage electrode, either by changing the effective geometry, or the affecting the resistivity. This tetrapolar technique is used often in resistance/impedance measurements in non-medical fields.

[0082] If fewer electrodes **18** are desired or necessary (for example, if only three electrodes **18** are present, and used for another purpose, as when making an admittance measurement using a right ventricular implanted defibrillator lead, with a large shocking coil, ring, and tip conductor [1], [2]), then any electrode connected to both a current generation and voltage measurement should be the largest possible. This ensures that if electrode fouling occurs, it is likely that the change in total impedance will not affect the large percentage of the area. For example, $R=\rho*L/A$, and if the A is very large, then a change in resistivity of a small area $\Delta\rho/\Delta A$ will not affect the R by very much, even if Δrho is large. Another example of three electrodes is when the next generation of Impella devices removed the pigtail, and replace the tip of the catheter with the blood inlet valve, and this is used as electrode one, and two additional electrodes are placed more proximally but still within the LV, this would be another design with 3 electrodes.

[0083] Electrode Spacing—If the outer two electrodes (**1** and **4**) are current generating, and the inner two electrodes (**2** and **3**) are voltage measuring, a naïve approach would be to equally space them. However, the sensitivity of a constant-current volume measurement is largest when the location of the current and voltage electrodes **18** is close together (that is, **1** and **2** are close together, 3 and 4 are close together), and far apart from the other pair (**2** and **3** are far apart).

[0084] Additionally, any admittance change between current and voltage pairs (between 1 and 2, or between 3 and 4) will inversely affect the total admittance, a concept called "negative sensitivity"

[0085] As an example: consider a complex impedance measurement. If a high resistance, zero capacitance object enters between electrodes **2** and **3**, then the real impedance measured will increase (because of the increased resistance to current flow, measured as a larger voltage on **2** and **3**). If the same object enters between 1 and 2 instead, the real impedance will decrease (because the same voltage drop occurs between 2 and 3). This is the concept known as "negative sensitivity", and was first discussed by Larson et al [**3**]. In general, electrodes **1** and **2** (and also electrodes **3** and **4**) should therefore be placed as close together as possible, given any limitations that must be worked around considering the geometry of the catheter shaft **20**.

[0086] Ideal Electrode Geometry—The ideal physically realizable electrode for an admittance measurement would be a sphere, because it would allow for current output and voltage input from all directions simultaneously. However, to be disposed on a shaft **20** like a catheter, the closest that can be achieved is a ring. Typically, single electrodes are ring shaped, and about as long as their diameter. Using a ring shape makes the measurement independent of the rotational angle of the catheter. This allows the connection to the ring to be made within the catheter body (which is usually non-conducting) and keep the wiring **24** harness from affecting the impedance measurement. Additionally, it is not generally desirable to minimize the area of the electrode, because the impedance of the electrode itself should remain low to avoid affecting the measurement. This can be done by using a material with extremely low resistivity (usually at considerable cost if it remains biocompatible) or it can be done more easily by using a larger surface area. It has been found that a length about the size of the diameter is sufficient. In general, the ring size should be thin (the length L should be shorter than the diameter, d). Additionally, the cross-sectional area $\pi*d*L$ should be large enough that the resistance when placed in normal saline is <10 Ohms. The specific dimensions relate to the material properties of the electrode, and the geometry used (thin electrodes with $L<<d$ will have high resistance. Large d electrodes require a large catheter body, but will have a lower resistance). For the electrodes **18**, the diameter should be the same as the catheter tubing diameter. The electrode diameter has a range of 2-5 mm and the electrode width to be 1-3 mm.

[0087] Wiring **24** Considerations-Connection of the electrodes **18** to the current source and voltage measurement is non-trivial, and in general, long, closely spaced wiring **24** creates a distributed capacitance that must be accounted for when calibrating. Wiring **24** must also be attached to the electrodes **18** in some way, ideally from the inside of the electrode ring. The catheter body is usually made of a non-conducting material, and if there is no necessary lumen, the wire routing can be made internal to the catheter, ensuring that the electrode surface area is not affected by the wire insulation. However, it is acceptable to route the wires outside of the catheter body, in particular when the lumen will need to be used, as in Embodiment 1 below. In these instances, the wiring **24** should be as thin as possible,

bonded to the electrode in a way that uses minimal external surface area (so as not to affect the measurement). The wires themselves should be placed farther apart to minimize their effects on capacitance, and should not be coiled so as to minimize inductance effects.

[0088] Another potential advantage of having thin wires is that often times catheters only have lumens because they need to remain patent for the flow of a liquid. Thin wires can more easily avoid impeding this flow of liquid either physically, or avoid being used as a scaffold for clotting. Additionally, thinner wires are more easily capable of being built into the lumen walls to completely avoid these effects.

[0089] The wires leading to each of the four electrodes **18** create a capacitance between them. In general, it is possible to calibrate out if the wires stay the same distance from one another over the heartbeat. This is because changing distance between the wires over the heartbeat could be misrepresented as change in capacitance measured in myocardium. If the electrodes are fixed on the shaft of the Impella, the electrodes would not move relative to one another.

[0090] Wire attachment is accomplished either by directly soldering the wire to the electrodes **18** themselves (typically from the inside of the lumen through a bored hole) or by using conductive epoxy solder paste through the same hole. It is possible to attach electrodes **18** to wires on the outside, but sensitivity to changes in the area of the solder joint may be changed by the electrical properties of the wire and attachment paste/solder. Electrical properties of the wire and attachment paste/solder are different depending on geometry, material, and material interface type, and these can all be either modeled using finite elements, or empirically measured in vitro using prepared saline that has the conductivity of blood. The ideal configuration is to incorporate the wires into the wall of the Impella catheter.

[0091] The wires used to connect to the electrodes **18** will be **40** to **48** AWG to minimize any increase to the overall outer diameter of the pump. The wires should be insulated. Embedding the wires in the walls fixes their position with respect to one another, providing a constant resistive contribution. This will help with two factors: A) ease of calibration by keeping the effects of the wires constant, and B) it would allow keeping the outer diameter of the pump itself the same (which is an advantage surgically, because it means you do not need to increase the size of the delivery sheath or hole in the vessel).

[0092] Design for noise-band immunity—Admittance measurement in many different potential configurations has been discussed thoroughly in the past. When making these types of measurements in the presence of noise, analog or digital filtering can be employed to some success. However, when the noise band of interference is small, and does not span the entire optimal range of admittance measurement (10 kHz-100 kHz), [4], a change in current stimulation frequency and an aggressive bandpass filter on the voltage input can be used to avoid the noise entirely.

[0093] There are a few advantages to characterizing the aggressiveness of the noise in the Fourier domain. The closer a noisy band is to the frequency of the current source, the harder it is to use a filter, either analog or digital, to separate the signal from the noise. Using high Q analog filters can be expensive in parts, and high Q digital filters can be expensive computationally. Delays due to digital filtering at high Q can also pose problems. Changing the stimulation frequency of the current generation circuit only requires changes in the oscillator that is being used, allowing for cheaper and faster components to provide the signal processing necessary to make a complete measurement.

[0094] Improving SNR with dynamic SinDAC frequency—It is possible to choose a signal generation technique that will allow for small changes in the generated current frequency using only software, provided the signal generation is driven by a microcontroller clock or other oscillator that is sufficiently higher than the current generation frequency. In full designs such as those that use high Q analog filters on the voltage sampling section, only small changes in the current frequency generation are useful (less than 5% difference from the initial frequency), because the SNR of the returning voltage will suffer from degradation by the filter. Typically, the waveform is represented in microcontroller memory as an N-point waveform signal (a sine wave) reproduced point-by-point on a Digital to Analog Converter (a SinDAC) that has an output rate at or near the clock frequency. This limits the upper bounds of the SinDAC frequency output per the following equation:

$$\text{SinDAC frequency (Hz)} = \text{Clock Speed (Hz)}/\text{Length of Waveform N} \times \text{divider M}$$

[0095] Having a higher N value or divider M increases the fidelity and stability of the current outputs at the cost of max SinDAC frequency, while having a lower clock speed directly reduces the maximum SinDAC frequency. Generally, there are only a few (10+) discrete speeds at which the SinDAC can operate in this design, but a few hundred Hz difference may reduce the noise faster than the signal in such a way as to improve the SNR substantially, leading to improvement.

[0096] In one embodiment, a change of about 800 Hz in the SinDAC frequency over 6 steps was created, by setting the rate of the SinDAC using the ADC interrupt frequency. Given an 80 MHz clock rate, and an N=32 point sine wave with an M=125 divider, sufficiently clean signals are produced at a SinDAC frequency of 20 kHz. Changing the divider M changes both the ADC sampling rate and the output of the N=32 point sine wave, synchronizing both the SinDAC current and the sampling of the returning voltage. These outputs would be well within the roll-off of a bandpass filter used to precondition the returning voltage signal, allowing a potential increase in Signal to Noise Ratio.

[0097] Dynamic noise-filtering with dynamic SinDAC frequency-One way to remove the limitations of only a few discrete speeds of SinDAC is to change the filtering technique on the voltage inputs by using a mixed-signal design switched-capacitor filter network with a high Q (ideally 4-8, given a chip like the Maxim 7491).

[0098] Improving SNR while sacrificing signal bandwidth-One way to improve SNR is to collect and process a buffer of data with a longer time interval. For example, if the buffer length is 2 ms, then volume versus time can be measured at 500 Hz. However, if the buffer length is increased to 20 ms, volume versus time is measured at 50 Hz, but SNR is greatly improved.

[0099] Left ventricular pressure—To improve clinical usefulness of the invention it is possible to include a pressure sensor **51** within the left ventricle. The challenge is not necessarily the size of the transducer, but the cost of routing

three additional wires along the cardiac assist device **14**. One solution to the device **14** diameter is to embed an embedded computer **53** along with the pressure sensor **51** distal to the inlet port **34** of the cardiac assist device **14**. FIG. **12** shows a flexible printed circuit board **55** wrapped around the shaft **20**. The printed circuit board **55** has the embedded compute **53** and the pressure sensor **51**. FIG. **13** shows the embedded computer **53** and pressure sensor **51** is interfaced to the main computer **22** with a cable **57** having 3 or more wires. In this configuration only 3 wires are necessary to implement both admittance-derived volume and left ventricular pressure. One wire is voltage supply, one wire is ground, and the third wire is serial output. The serial output encodes the raw measurements, which will then be processed in the usual way on the main computer **22**. In this configuration the admittance circuitry (sinDAC, and ADC) is included on the flexible PCB wrapped around the tip of the pump.

[0100] Clinical Use Cases: General—The ability of MCS **32** devices to maintain peripheral perfusion while mechanically unloading the heart **12** has the potential to improve mortality across at least three large groups of patients (**7**): 1. high risk percutaneous coronary intervention (PCI), 2. acute myocardial infarction (MI) with or without cardiogenic shock, and 3. acute decompensated heart **12** failure.

[0101] While the first category of high-risk PCI is an elective surgery and is typically performed over a surgical (short) period, for the last two categories, MCS **32** devices are implanted for up to 6 days as a bridge-to-recovery or bridge-to-decision for a more long-term ventricular assist implant. In these patients, indwelling time is longer, and bridging to recovery is not guaranteed.

[0102] Goals of hemodynamic support—The overarching goal of hemodynamic support is to maximize function by increasing both Cardiac Output (CO, the MCS **32** control point), and Mean Arterial Pressure (MAP, optimized by medication). The product is the Cardiac Power Output (CPO= [total CO*MAP]/451) and low CPO is now well accepted as the single most important correlate of mortality in cardiogenic shock. Studies have also shown that the goal of keeping the CPO ≥ ~0.6 W with MCS **32** devices is predictive of decreasing heart failure mortality at 30 days. While the measurement of pressure is currently integrated into many MCS **32** devices (e.g., the Impella device has an integrated pressure sensor **16**, used for device placement), the only control point for an MCS **32** device is the motor **26** speed, which increases CO with increasing motor **26** speed (flow). In practice, this translates to a clinical support goal of setting the MCS **32** device flow as high as possible without the causing suction due to high pump speeds (where the motor **26** is spinning, but reduced blood is moving through the MCS **32**). The positive impact of an MCS **32** device is highly dependent on the flow rate of the pump, which can be adjusted in the majority of pumps, but the initial flow rate is rarely changed during recovery.

[0103] The key indicator of patient stability is Total Cardiac Output (total CO), which is the summation of the pump CO (the amount of blood in Liters ejected by the pump per min), and the native CO (The amount of blood in Liters ejected by the heart per min). Total CO=pump CO +native CO. Native CO is dependent on patient health, while pump CO is controlled by the operator of the MCS **32** device, and estimated using the current draw on the motor **26**, or measured RPM, or in some cases, by a flow measurement integral to the pump that is either EM, acoustic, or pressure differential based.

[0104] Clinical Use Case **1**: Native CO to inform start of weaning from MCS **32**-MCS **32** device implantation is not without risk, and longer indwelling times can lead to infectious complications (in the form of local infections, bacteremia, and sepsis), leg ischemia, and blood hemolysis. Patients who suffer from these complications face a substantially longer hospital stay and have greater complications. Removal of the MCS **32** device requires "weaning" the patient from pump support by slowly (over hours) reducing pump speeds and closely monitoring hemodynamics to ensure that the heart **12** does not decompensate from lack of support. The decision to begin weaning the patient from the MCS **32** device relies heavily on a subjective clinical assessment of the patient (instead of an objective measurement of native heart CPO). In some research institutions, CPO is estimated directly using pressure measurement, and transthoracic echocardiography to look at native CO (Ejection Fraction) during the hours long weaning process, but this requires the resources of a surgeon, a heart failure cardiologist, and a noninvasive cardiologist experienced in echocardiographic parameters. This is a huge amount of resources if the weaning process takes a long time, or if recovery is not actually complete. One potential clinical use of measuring Native CO using the Abiomed Impella device, is that it can provide a real-time assessment of a patient's native heart condition.

[0105] Clinical Use 2: Native CO for automatic weaning control input-Weaning a patient from an implanted MCS **32** device need not be a manual process. Native CO can be measured in real time using the invention described alongside pump flow to provide insight into the slowly improving condition of a patient supported by MCS **32**. Weaning would happen in this way optimally, allowing for total CO to remain constant, while the patient's heart **12** recovers on its own. A number of well known-control algorithms could be applied automatically to the pump flow control based on the patient's measured, Native CO.

[0106] Clinical Use 3: If pressure is available, then the device is capable of measuring native heart pressure volume loops. Pressure-volume loops provide valuable information about the hemodynamic status of the heart.

Embodiment 1: Used in Preliminary Studies

[0107] Electrodes **18** used: The electrodes **18** used in this embodiment were purchased in two sizes, to accommodate the two different catheter body sizes, from Johnson Matthey, UK. Two were used as electrodes **1** and **2** (with a smaller diameter), and two were used as electrodes **3** and **4** (with a larger diameter). The final embodiment is the bottom electrode configuration.

[0108] Electrode Spacing: Electrode spacing was chosen to maximize the span of the chamber of interest (the left ventricle) while ensuring that all four electrodes **18** would stay below the valve (and therefore in the chamber of interest). This was done by making sure that the most proximal electrode (electrode **4**) is close to the radiopaque marker **30** that cardiologists use to place the pump inlet inside the LV, and the pump outlet outside the LV (in the aorta). By co-locating electrodes **3** and **4** with the radiopaque marker **30**, it is ensured that the electrodes **18** will be within the LV if the pump is functioning correctly.

[0109] Electrode Wiring **24**: Wiring **24** considerations for the preliminary studies embodiment required us to keep the wiring **24** on the outside of the lumen for the distal electrodes **1** and **2**. This was done to keep the lumen free and clear for use by a guidewire to implant the catheter. The wiring **24** on the proximal electrodes **3** and **4** is run internal to the catheter body to avoid changing their large surface area, and the wiring **24** on the distal electrodes **1** and **2** was run outside of the catheter with minimal contact area (see FIGS. **3**, **6**, **9** and **10**). The key consideration for the diameter (or gauge) of the wire is that they should be as thin as possible. If wiring **24** is run internal to the lumen between the pump inlet and outlet, the requirement to be thin is to reduce impediment of blood flow or required guidewires for implant. If wiring **24** is run external to the pump, then the wiring **24** is required to be thin to reduce the size of the sheath necessary to implant (allowing for an easier surgical technique). Ideally the wiring would be incorporated into the wall of the Impella.

[0110] In another embodiment, as shown in FIG. **11**, the wiring **24** runs internal to the plastic body (but not in the lumen space). This will be similar in function to the way that nitinol is embedded in the catheter body itself for the purpose of making the Impella catheter stiffer. A tradeoff in volume sensitivity to allow the electrodes **18** to be placed closer together will also be exploited.

[0111] Motor **26** noise quantification: Fourier frequency analysis of the motor **26** noise signal during pump operation was used to determine the optimal frequencies to use for the cardiac volume measurements. It was determined that the pump noise was at 50 khz, and at 100 kHz at all 9 pump speeds for an Abiomed Impella device (Danvers, MA), and did not overlap with the measurement. It was found from FIG. **7** that any frequency at least 5 kHz away from DC, and not an integer multiple of 50 kHz could be utilized for the admittance-based volume measurement. 20 kHz was chosen. In a fictitious example where 30 kHz was where motor **26** noise was detected, any frequency from 10 kHz to 25 kHz, or from 35 kHz to 100 kHz, for example, can be chosen. FIG. **7** is a Fourier analysis of motor **26** electromagnetic noise vs. admittance signal for all 9 motor **26** speeds (P1-P9). Note that the signal is 40 dB higher than the surrounding noise floor (60 dB), meeting our success. Motor **26** noise Quantification. Signal is at 20 kHz, note peaks at 50 and 100 kHz representing motor **26** noise. Each color is a different pump speed.

[0112] The present invention pertains to an apparatus **100** for a heart **12** of a patient, as shown in FIG. **14**. The apparatus **100** comprises a first cardiac assist device **102** adapted to be implanted into the patient to assist the heart **12** with pumping blood which increases load on the heart **12**. The apparatus **100** comprises a second cardiac assist device **14** adapted to be implanted into the patient to assist the heart **12** with pumping blood which vents the heart **12** simultaneously with the first cardiac assist device **102**. The first cardiac assist device **102** and the second cardiac assist device **14** tuned to maximize blood flow to the body of the patient, while resting the heart **12** so the heart **12** may recover function.

[0113] The second cardiac assist device **14** may be a temporary mechanical circulatory support (MCS **32**) device which is a catheter-mounted blood pump that draws blood from a left ventricle of the heart **12** through an inlet port of the MCS **32** and expels blood into an ascending aorta **36** of the heart **12**. The first cardiac assist device **102** draws venous blood, oxygenates the venous blood, and returns the venous blood after the venous blood has been oxygenated to an artery. Alternatively, the second cardiac assist device **14** may include a balloon in the aorta to inflate during diastole and deflate during systole.

[0114] The apparatus **100** may include a sensor **16** adapted to be implanted into the patient. The sensor **16** in communication with the first cardiac assist device **102**, the second cardiac assist device **14** and the heart **12** which measures native volume of the heart **12**. The sensor **16** may include a computer **22** for data acquisition and analysis of signals, such as admittance signals acquired from the heart **12** of the patient. The computer **22** may use an algorithm to coordinate and tune simultaneous operation of the first and second cardiac assist devices to maximize blood flow to the body of the patient while resting the heart **12** so the heart **12** may recover function. The computer **22** may obtain diagnostic information about the heart **12**, which includes native cardiac output (CO) or SW derived from a LV PV loop, when the first and second cardiac assist devices are in simultaneous operation in the patient while the patient's heart **12** is in recovery.

[0115] The present invention pertains to a method for treating a heart **12** of a patient. The method comprises the steps of assisting the pumping of blood from the heart **12** with a first cardiac assist device **102** implanted into the patient which increases load on the heart **12** and a second cardiac assist device **14** implanted in the heart **12** which vents the heart **12** simultaneously with the first cardiac assist device **102**. There is the step of obtaining diagnostic information about the heart **12** as a function of native cardiac output (CO) or SW from LV PV loops from an implanted sensor **16** in communication with the heart **12** while the implanted first and second cardiac assist devices are in operation in the patient assisting the pumping of blood in the patient. There is the step of tuning the first cardiac assist device **102** and the second cardiac assist device **14** to maximize blood flow to the body of the patient, while resting the heart **12** so the heart **12** may recover function.

[0116] There is the step of dynamically changing the operation of the first cardiac assist device **102** and the second cardiac assist device **14** while tuning their interaction while the first and second cardiac assist devices are simultaneously operating while implanted in the patient. There are the steps of reducing the flow from the first and increasing flow from the second cardiac assist devices, or the reverse, as the native CO or SW increases, and determining how the first and second cardiac assist devices operating simultaneously while implanted in the patient will be increased and/or weaned relative to one another as the native CO or SW increases.

[0117] In the operation of the invention, improving mortality with Pressure Volume Loops—The overarching goal of hemodynamic support is to maximize function by increasing both Cardiac Output (CO), and Mean Arterial Pressure (MAP, optimized by medication). The product is the Cardiac Power Output (CPO= [CO*MAP)]/451) and low CPO is now well accepted as the single most important correlate of mortality in cardiogenic shock. Studies have also shown that the goal of keeping the CPO >~0.6 W with MCS **32** devices is predictive of decreasing heart **12** failure and mortality at 30 days. While the measurement of pressure is currently integrated into many pVAD devices (e.g., the Impella device

has an integrated placement pressure sensor, and is being replaced soon by a high-fidelity pressure sensor), the only control point for a pVAD device or ECMO is the motor speed, which increases CO with increasing motor speed.

[0118] The use of Native Cardiac Output (Native CO) optimizes ECpella treatment-During continuous use of ECpella, the "total CO" delivered to the body comes from two components: "total CO"= "native CO"+ "device CO". Native CO is the amount of blood ejected from the LV by the recovering heart **12**, and device CO is the amount of blood pumped forward by ECpella. During treatment, the native CO from the heart **12** rises, as it recovers slowly due to recovery and decreased load, signaling improvement. Ideally, a device used with ECpella would have on-board access to a native CO measurement that is accurate and real-time, and thus enable motor-speed tuning (both ECMO and Impella) to automatically respond to changing conditions by changing device CO as native CO rises. Native CO and device CO is determined as described above.

[0119] CO measurement using admittance-Admittance measurement is an implantable blood volume measurement recently validated against 3D Echo in humans that has the capability of solving the issues of dynamic myocardial removal found in traditional conductance measurement (parallel conductance), which is used as the basis for a "physician in the loop" ECpella weaning algorithm. The use of admittance has been published extensively over the past 20 years. At frequencies from 10 kHz-100 kHz, volume signal myocardial contribution is both resistive and capacitive, while blood contribution is purely resistive. Compared to traditional conductance measurements that use a single value for parallel structures, admittance exploits the differing electrical properties of blood (resistive) and myocardium (resistive and capacitive) to separate them in real-time, resulting in a signal that is less dependent on catheter position, improved signal to noise ratio in the presence of parallel muscle conductance, and feasible of integration into an implanted device already validated through a published human trial (RECHARGE). In the RECHARGE trial, admittance-based measurement was shown to be as accurate as 3D trans-thoracic echocardiography for the purpose of measuring chamber volume in a research-only device, and more accurate due to decreased standard deviation of the measurement.

[0120] The ECMO, while assisting the heart **12** of a patient, increases pressure and overloads the pumping chamber (left ventricle) LV. The Impella decompresses or vents the LV while assisting the heart **12** of the patient simultaneously with the ECMO assisting the circulation **12** of a patient by eliminating shock. ECMO reduces native heart CO due to increased loading, but the ECMO and the Impella increase blood flow to the body. Because ECMO loads the LV so much, it gets weaker and does not recover. Thus, ECMO increases oxygenated blood supply to the body. Venting the LV with Impella while the ECMO is in operation, allows the native heart to rest and recover.

[0121] The computer **22** continually measures hemodynamics (the LV pressure-volume loop) to detect cardiac recovery of the patient and controls the shift in mechanical cardiac support from ECMO to Impella to guide the weaning process. The computer **22** uses a software program having an algorithm for real time optimization of LV function using LV pressure-volume loop analysis which is based on native CO of the heart **12** of the patient. Physicians use the optimization of LV function from the computer **22** to inform them of optimal pump speeds for both ECMO and Impella pVAD at any given moment to modify the pump speeds as necessary from the optimization information. If so desired, instead of the physicians implementing the optimization information by modifying the pump speeds, the computer **22** itself can tune the pump speeds of the ECMO and Impella pVAD based on the real time optimization algorithms including the use of Artificial Intelligence.

[0122] In the ECpella combo, during titration and maintenance of ECMO, the Impella is operated at lower flows (1-2 L/min) than typical for support (up to 3-5 L/min) because it is primarily functioning to decompress the LV. During weaning from ECMO, the Impella is used for its obvious benefit as a more LV "friendly" MCS **32** device that still provides forward flow from the weakened heart **12**. ECMO can therefore be used as "a bridge to", for instance, a bridge-to-recovery (Impella). For example, as the native CO of the heart **12** of the patient increases, the speed of the ECMO pump can be reduced by small increments gradually over time. Typical weaning protocols reduce the flow by 0.5 L/min each 24-hour period. Smaller increments like 0.1 L/min every 1 hour (or even more frequently) could accelerate both the weaning and recovery processes. The computer **22** constantly and continuously in real time monitors as the small increments are gradually implemented over time, uses the native CO with LV pressure volume loops to ascertain if the heart **12** is maintaining or continuing to increase the native CO. If the heart **12** is maintaining or continuing to increase the native CO, the reduction by small increments of ECMO pump speed over time will continue. At the same time, the pump speed of the Impella pVAD may also be reduced by small increments gradually over time, with the computer **22** constantly and continuously in real time using the native CO with LV pressure loops to monitor the operation of the native heart **12**. The pump speed of the Impella pVAD may be accordingly modified but with a lag time behind the modification of the ECMO, to further assist the heart **12** and the transition away from ECMO support. If desired, the patient could be completely weaned from the ECMO, with the ECMO removed from the patient, while the Impella remains in place with the patient and continues operating until it is appropriate for the Impella to be completely weaned off of the patient. If for any predetermined time, for instance two seconds, the computer **22** determines that the native CO is decreasing, the computer **22** may stop the weaning process (speed of the motors), and instead increase the motor speeds of the Impella pVAD and/or ECMO, by small increments, depending on the optimization of both load on and CO of the native heart **12**. At all times, the CPO should be maximized by the computer, or manually by the physician in charge.

[0123] Works Cited, all of which are incorporated by reference, herein.

[0124] [1] D. E. Haines et al., "Validation of a defibrillation lead ventricular volume measurement compared to three-dimensional echocardiography," Heart Rhythm, June 2017.

[0125] [2] L. M. Holt, M. L. Oglesby, A. P. Wang, J. W. Valvano, and M. D. Feldman, "A Real-Time Hemodynamic ICD Measurement: Evaluation in Chronically Implanted Canines With Pacing-Induced Dilated Cardiomyopathy," J Am Coll Cardiol EP, vol. 5, no. 6, pp. 742-743, June 2019 PMID: 31221363.

[0126] [3] E. R. Larson, M. D. Feldman, J. W. Valvano, and J. A. Pearce, "Analysis of the Spatial Sensitivity of Conductance/Admittance Catheter Ventricular Volume Estimation," IEEE Trans. Biomed. Eng., vol. 60, no. 8, pp. 2316-2324 August 2013.

[0127] [4] K. Raghavan et al., "Electrical Conductivity and Permittivity of Murine Myocardium," IEEE Trans. Biomed. Eng., vol. 56, no. 8, pp. 2044-253 August 2009.

[0128] U.S. Patents and application

[0129] U.S. Pat. No. 10,420,952

[0130] U.S. Pat. No. 10,376,177

[0131] U.S. Pat. No. 10,076,669

[0132] U.S. Pat. No. 9,820,673

[0133] U.S. Pat. No. 9,295,404

[0134] U.S. Pat. No. 7,925,335

[0135] U.S. Pat. No. 6,494,832

[0136] 20110152661

[0137] Although the invention has been described in detail in the foregoing embodiments for the purpose of illustration, it is to be understood that such detail is solely for that purpose and that variations can be made therein by those skilled in the art without departing from the spirit and scope of the invention except as it may be described by the following claims.

1. An apparatus for a heart of a patient comprising:

a first cardiac assist device adapted to assist the heart with pumping blood which increases load on the heart;

a second cardiac assist device adapted to be implanted into the patient to assist the heart with pumping blood which vents the heart simultaneously with the first cardiac assist device, the first cardiac assist device and the second cardiac assist device both tuned to maximize blood flow to the body of the patient, while resting the heart so the heart may recover function, the second cardiac assist device has a shaft that is adapted to be positioned in the heart, the second cardiac assist device includes a motor and an impeller disposed in the shaft which is driven by the motor to assist the heart with pumping blood, the pump draws blood from a left ventricle of the heart through an inlet port of the shaft and expels blood into an ascending aorta of the heart through an outlet port of the shaft, thereby reducing mechanical load on the heart and promoting recovery; and

a sensor adapted to be implanted into the patient, the sensor in communication with the second cardiac assist device and the heart which directly measures native volume of the heart.

2. The apparatus of claim **1** wherein the second cardiac assist device is a temporary mechanical circulatory support (MCS) device which is a catheter-mounted blood pump that draws blood from a left ventricle of the heart through an inlet port of the MCS and expels blood into an ascending aorta of the heart, and the first cardiac assist device draws venous blood, oxygenates the venous blood, and returns the venous blood to an artery, or the second cardiac assist device includes a balloon in the aorta to inflate during diastole and deflate during systole.

3. The apparatus of claim **2** wherein the sensor includes electrodes attached to the second cardiac assist device that produce signals which are used to measure the native volume of the heart.

4. The apparatus of claim **3** wherein the sensor includes a computer for data acquisition and analysis of the signals.

5. The apparatus of claim **4** wherein the electrodes are in direct contact with the shaft that is positioned in the heart, the computer in communication with the electrodes.

6. The apparatus of claim **5** wherein the computer obtains diagnostic information about the heart, which includes native cardiac output (CO) or SW, as well as a native heart LV PV loop, when the first and second cardiac assist devices are in simultaneous operation in the patient while the patient's heart is in recovery.

7. The apparatus of claim **6** wherein the computer produces the signals which include electrical currents to the electrodes and measures corresponding voltages to make admittance-based measurements and analyze the admittance-based measurements to make real-time admittance-based volume measurements of the heart to determine the native cardiac output of the patient.

8. The apparatus of claim **7** wherein the currents have a frequency and the sensor dynamically shifting the frequency of the currents to avoid noise in the patient to the sensor.

9. The apparatus of claim **8** including a pressure sensor adapted to be implanted into the patient, the pressure sensor in contact with the shaft of the cardiac assist device and in communication with the heart which monitors left ventricular pressure while the cardiac assist device is in operation and with the computer plots native pressure volume loops while the cardiac assist device is in operation.

10. A method for treating a heart of a patient comprising the steps of: assisting the pumping of oxygenated blood to the body with a first cardiac assist device which increases load on the heart and a second cardiac assist device implanted in the heart which vents the heart simultaneously with the first cardiac assist device, the second cardiac assist device has a shaft that is adapted to be positioned in the heart, the second cardiac assist device includes a motor and an impeller disposed in the shaft which is driven by the motor to assist the heart with pumping blood, the pump draws blood from a left ventricle of the heart through an inlet port of the shaft and expels blood into an ascending aorta of the heart through an outlet port of the shaft, thereby reducing mechanical load on the heart and promoting recovery; obtaining diagnostic information about the heart as cardiac output (CO) and/or SW and LV PV loops from an implanted sensor in communication with the heart while the first and second cardiac assist devices are in operation in the patient assisting the pumping of blood in the patient, the sensor in communication with the second cardiac assist device and the heart, the sensor includes electrodes attached to the second cardiac assist device that emit signals which are used to directly measure native volume of the heart, and the electrodes are in contact with the shaft that is positioned in the heart, the sensor includes a computer for data acquisition and analysis of the signals, the computer in communication with the electrodes; and tuning the first cardiac assist device and the second cardiac assist device to maximize blood flow to the body of the patient based on the native volume of the heart, while resting the heart so the heart may recover function.

11. The method of claim **10** including the steps of reducing the flow from the first and second cardiac assist devices as the native CO or SW increases, and determining how the first and second cardiac assist devices operating simultaneously while implanted in the patient will be weaned relative to one another as the native CO or SW increases.

12. The method of claim **11** including the step of dynamically changing the operation of the first cardiac assist device and the second cardiac assist device while tuning their interaction while the first and second cardiac assist devices are simultaneously operating while implanted in the patient.

13. The apparatus of claim **12** wherein the computer of the sensor dynamically shifting the frequency of the currents to avoid noise from the cardiac assist device.

14. The apparatus of claim **11** wherein the frequency of the currents include currents at a desired frequency and the computer includes a signal generator which generates the currents at the desired frequency and causes changes in the frequency of the currents when dynamically shifting the currents.

* * * * *