



(51) International Patent Classification:

A61B 5/00 (2006.01) A61B 5/021 (2006.01)

(21) International Application Number:

PCT/US2017/039974

(22) International Filing Date:

29 June 2017 (29.06.2017)

(25) Filing Language:

English

(26) Publication Language:

English

(30) Priority Data:

62/360,088	08 July 2016 (08.07.2016)	US
15/634,918	27 June 2017 (27.06.2017)	US

(71) Applicant: **EDWARDS LIFESCIENCES CORPORATION** [US/US]; One Edwards Way, Irvine, CA 92614 (US).

(72) Inventors: **AL HATIB, Feras**; Edwards Lifesciences, One Edwards Way, Legal Department, Irvine, CA 92614 (US).

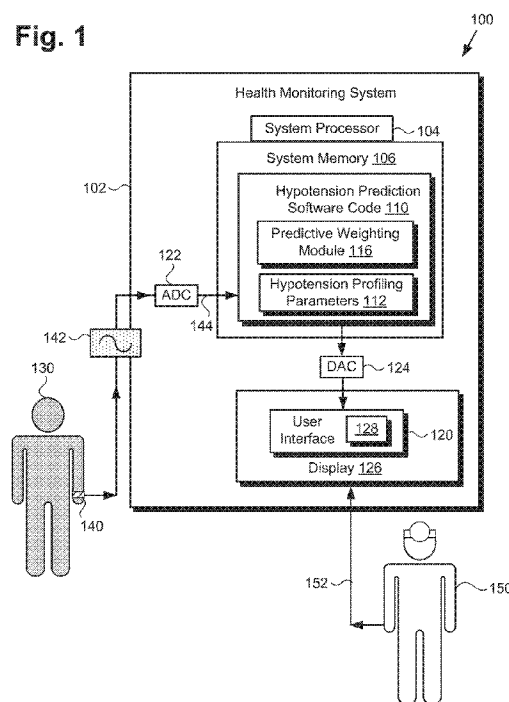
JIAN, Zhongping; Edwards Lifesciences, One Edwards Way, Legal Department, Irvine, CA 92614 (US). **BUDDI, Sai Prasad**; Edwards Lifesciences, One Edwards Way, Legal Department, Irvine, CA 92614 (US).

(74) Agent: **CRAPENHOFT, Michael** et al.; Edwards Lifesciences, One Edwards Way, Irvine, CA 92614 (US).

(81) Designated States (unless otherwise indicated, for every kind of national protection available): AE, AG, AL, AM, AO, AT, AU, AZ, BA, BB, BG, BH, BN, BR, BW, BY, BZ, CA, CH, CL, CN, CO, CR, CU, CZ, DE, DJ, DK, DM, DO, DZ, EC, EE, EG, ES, FI, GB, GD, GE, GH, GM, GT, HN, HR, HU, ID, IL, IN, IR, IS, JO, JP, KE, KG, KH, KN, KP, KR, KW, KZ, LA, LC, LK, LR, LS, LU, LY, MA, MD, ME, MG, MK, MN, MW, MX, MY, MZ, NA, NG, NI, NO, NZ, OM, PA, PE, PG, PH, PL, PT, QA, RO, RS, RU, RW, SA, SC, SD, SE, SG, SK, SL, SM, ST, SV, SY, TH, TJ, TM, TN, TR, TT, TZ, UA, UG, US, UZ, VC, VN, ZA, ZM, ZW.

(54) Title: PREDICTIVE WEIGHTING OF HYPOTENSION PROFILING PARAMETERS

Fig. 1



(57) Abstract: A system having a processor obtain a digital hemodynamic data from a hemodynamic sensor, obtain one or more vital sign parameters characterizing vital sign data from the digital hemodynamic data, derive differential parameters based on the one or more vital sign parameters, generate combinatorial parameters using the one or more vital sign parameters and the differential parameters, determine a risk score corresponding to a probability of a future hypotension event for the living subject based on a weighted combination of a plurality of hypotension profiling parameters including the one or more vital sign parameters characterizing vital sign data, the differential parameters and the combinatorial parameters, and invoke a sensory alarm if the risk score satisfies a predetermined risk criterion.

(84) Designated States (*unless otherwise indicated, for every kind of regional protection available*): ARIPO (BW, GH, GM, KE, LR, LS, MW, MZ, NA, RW, SD, SL, ST, SZ, TZ, UG, ZM, ZW), Eurasian (AM, AZ, BY, KG, KZ, RU, TJ, TM), European (AL, AT, BE, BG, CH, CY, CZ, DE, DK, EE, ES, FI, FR, GB, GR, HR, HU, IE, IS, IT, LT, LU, LV, MC, MK, MT, NL, NO, PL, PT, RO, RS, SE, SI, SK, SM, TR), OAPI (BF, BJ, CF, CG, CI, CM, GA, GN, GQ, GW, KM, ML, MR, NE, SN, TD, TG).

Published:

— *with international search report (Art. 21(3))*

PREDICTIVE WEIGHTING OF HYPOTENSION PROFILING PARAMETERS

5

BACKGROUND

Hypotension, or low blood pressure, can be a harbinger of serious medical complications, and even mortality, for patients undergoing surgery and those acutely or critically ill patients receiving treatment in an intensive care unit (ICU). The dangers associated with the occurrence of hypotension in a patient are due both to the potential injury caused by the hypotension itself and to the many serious underlying medical disorders that the occurrence of hypotension may signify.

In and of itself, hypotension in surgical patients or critically ill patients is a serious medical condition. For example, in the operating room (OR) setting, hypotension during surgery is associated with increased mortality and organ injury. Even short durations of extreme hypotension during surgery are associated with acute kidney injury and myocardial injury. Among critically ill patients, in-hospital mortality may be nearly doubled for patients experiencing hypotension after emergency intubation. For surgical patients and seriously ill patients alike, hypotension, if not corrected, can impair organ perfusion, resulting in irreversible ischemic damage, neurological deficit, cardiomyopathy, and renal impairment.

In addition to posing serious risks to surgical patients and critically ill patients in its own right, hypotension can be a symptom of one or more other serious underlying medical conditions. Examples of underlying conditions for which hypotension may serve as an acute symptom include sepsis, myocardial infarction, cardiac arrhythmia,

pulmonary embolism, hemorrhage, dehydration, anaphylaxis, acute reaction to medication, hypovolemia, insufficient cardiac output, and vasodilatory shock. Due to its association with such a variety of serious medical conditions, hypotension is relatively common, and is often seen as one of the first signs of patient deterioration in the OR and
5 ICU. For instance, hypotension is seen in up to approximately thirty-three percent of surgeries overall, and up to eighty-five percent in high risk surgeries. Among ICU patients, hypotension occurs in from approximately twenty-four percent to approximately eighty-five percent of all patients, with the eighty-five percent occurrence being seen among critically ill patients.

10 Conventional patient monitoring for hypotension in the OR and ICU settings can include continuous or periodic blood pressure measurement. However, such monitoring, whether continuous or periodic, typically provides no more than a real-time assessment. As a result, hypotension in a surgical patient or critically ill patient is usually detected only after it begins to occur, so that remedial measures and interventions cannot be
15 initiated until the patient has entered a hypotensive state. Although, as noted above, extreme hypotension can have potentially devastating medical consequences quite quickly, even relatively mild levels of hypotension can herald or precipitate cardiac arrest in patients with limited cardiac reserve.

In view of the frequency with which hypotension is observed to occur in the OR
20 and ICU settings, and due to the serious and sometimes immediate medical consequences that can result when it does occurs, a solution enabling prediction of a future hypotension event, before its occurrence, is highly desirable.

SUMMARY

There are provided systems and methods for performing predictive weighting of hypotension profiling parameters, substantially as shown in and/or described in connection with at least one of the figures, and as set forth more completely in the
5 claims.

BRIEF DESCRIPTION OF THE DRAWINGS

Figure 1 shows a diagram of an exemplary system for performing predictive weighting of hypotension profiling parameters, according to one implementation;

Figure 2A shows an exemplary implementation for non-invasively detecting
10 arterial pressure at an extremity of a living subject;

Figure 2B shows an exemplary implementation for performing minimally invasive detection of arterial pressure of a living subject;

Figure 3 shows an exemplary system and a computer-readable non-transitory medium including instructions enabling performance of predictive weighting of
15 hypotension profiling parameters;

Figure 4 is a flowchart presenting an exemplary method for use by a health monitoring system to perform predictive weighting of hypotension profiling parameters;
and

Figure 5 shows a trace of an arterial pressure waveform including exemplary
20 indicia corresponding to the probability of future hypotension in a living subject.

DETAILED DESCRIPTION

The following description contains specific information pertaining to implementations in the present disclosure. One skilled in the art will recognize that the present disclosure may be implemented in a manner different from that specifically
5 discussed herein. The drawings in the present application and their accompanying detailed description are directed to merely exemplary implementations. Unless noted otherwise, like or corresponding elements among the figures may be indicated by like or corresponding reference numerals. Moreover, the drawings and illustrations in the present application are generally not to scale, and are not intended to correspond to
10 actual relative dimensions.

The present application discloses systems and methods for performing predictive weighting of hypotension profiling parameters. By converting data received from a hemodynamic sensor to digital hemodynamic data of a living subject, and by transforming the digital hemodynamic data to multiple hypotension profiling parameters,
15 the present solution employs a powerful multivariate model for predicting future hypotension.

The solution disclosed by the present application utilizes the multivariate model to determine a risk score corresponding to the probability of a future hypotension event for the living subject based on a weighed combination of the multiple hypotension
20 profiling parameters. In addition, by invoking a sensory alarm if the risk score satisfies a predetermined risk criterion, the present application discloses a solution that provides an early warning of a future hypotension event for the living subject, thereby

advantageously enabling health care workers to prepare a timely and effective intervention.

Figure 1 shows a diagram of an exemplary system for performing predictive weighting of hypotension profiling parameters, according to one implementation. Health monitoring system 100 includes hardware unit 102, which may be an integrated hardware unit, for example, including system processor 104, implemented as a hardware processor, analog-to-digital converter (ADC) 122, and system memory 106. As shown in Figure 1, health monitoring system 100 also includes hypotension prediction software code 110 including predictive weighting module 116, stored in system memory 106. System memory 106 is further shown to store hypotension profiling parameters 112 including one or more vital sign parameters characterizing vital sign data, which will be described in greater detail below.

As further shown in Figure 1, health monitoring system 100 also includes hemodynamic sensor 140 coupled to hardware unit 102, and display 126 providing user interface 120. In addition, health monitoring system 100 includes digital-to-analog converter 124 (hereinafter “DAC 124”), digital hemodynamic data 144 generated by ADC 122 from signal 142 received from hemodynamic sensor 140, and sensory alarm 128.

Health monitoring system 100 may be implemented within a patient care environment such as an intensive care unit (ICU) or operating room (OR), for example. As shown in Figure 1, in addition to health monitoring system 100, the patient care environment includes patient 130 (hereinafter “living subject 130”), and healthcare worker 150 (hereinafter “user 150”) trained to utilize health monitoring system 100. As

will be discussed in greater detail below, user interface 120 is configured to receive inputs 152 from user 150, and to provide sensory alarm 128 if a risk score predictive of a future hypotension event for living subject 130 satisfies a predetermined risk criterion.

Hemodynamic sensor 140 is shown in an exemplary implementation in Figure 1, and is attached to living subject 130. It is noted that hemodynamic sensor 140 may be a non-invasive or minimally invasive sensor attached to living subject 130. In one implementation, as represented in Figure 1, hemodynamic sensor 140 may be attached non-invasively at an extremity of living subject 130, such as a wrist or finger of living subject 130. Although not explicitly shown in Figure 1, in other implementations, hemodynamic sensor 140 may be attached non-invasively at an ankle or toe of living subject 130. Signal 142 received by health monitoring system 100 from hemodynamic sensor 140 may include signals corresponding to the arterial pressure of living subject 130, such as an arterial pressure waveform of living subject 130. Health monitoring system 100 and hemodynamic sensor 140 may be configured such that signal 142 may be received by health monitoring system 100 wirelessly, or via a wired connection with hemodynamic sensor 140.

According to the exemplary implementation shown in Figure 1, system processor 104 is configured to utilize ADC 122 to convert signal 142 to digital hemodynamic data 144. System processor 104 is further configured to execute hypotension prediction software code 110 to transform digital hemodynamic data 144 to multiple hypotension profiling parameters 112. It is noted that hypotension profiling parameters 112 include one or more vital sign parameters characterizing vital sign data, as well as differential and combinatorial parameters derived from the one or more vital sign parameters.

System processor 104 is further configured to execute hypotension prediction software code 110 to use predictive weighting module 116 to determine a risk score corresponding to the probability of a future hypotension event for living subject 130 based on a weighted combination of hypotension profiling parameters 112. In addition, system processor 104 is configured to execute hypotension prediction software code 110 to invoke sensory alarm 128 if the risk score satisfies a predetermined risk criterion. For example, hypotension prediction software code 110 may invoke sensory alarm 128 to warn of a hypotension event for living subject 130 predicted to occur approximately one to five minutes in the future, or up to approximately thirty minutes in the future.

In various implementations, sensory alarm 128 may be implemented as one or more of a visual alarm, an audible alarm, and a haptic alarm. For example, when implemented to provide a visual alarm, sensory alarm 128 may be invoked as flashing and/or colored graphics shown by user interface 120 on display 126, and/or may include displaying the risk score via user interface 120 on display 126. When implemented to provide an audible alarm, sensory alarm 128 may be invoked as any suitable warning sound, such as a siren or repeated tone. Moreover, when implemented to provide a haptic alarm, sensory alarm 128 may cause hardware unit 102 to vibrate or otherwise deliver a physical impulse perceptible to user 150.

It is noted that the risk score of living subject 130 is determined based on a weighted combination of hypotension profiling parameters 112, which are derived from signal 142 of living subject 130 received from hemodynamic sensor 140. Consequently, according to the inventive concepts disclosed by the present application, system processor 104 of health monitoring system 100 is configured to execute hypotension

prediction software code 110 to determine the risk score of living subject 130 without comparison with data corresponding to hypotension in other living subjects. In other words, hypotension prediction software code 110 determines the risk score of living subject 130 based on quantities derived from the one or more vital sign parameters
5 characterizing vital sign data, without reference to a hypotension patient database storing information regarding hypotension in patients other than living subject 130.

In addition to the functionality described above, in some implementations, system processor 104 may be configured to execute hypotension prediction software code 110 to identify a most probable cause of the future hypotension event for living subject 130.
10 For example, based on indicia included in digital hemodynamic data 144, hypotension prediction software code 110 may be able to identify poor vascular tone, low blood volume, or reduced cardiac contractility, to name a few exemplary causes, as a most probable cause of a predicted future hypotension event. Furthermore, in some implementations, system processor 104 may be configured to execute hypotension
15 prediction software code 110 to recommend a medical intervention for preventing the future hypotension event for living subject 130. With respect to the first and second example causes of hypotension identified above, administration of a vasoconstrictor may be recommended if poor vascular tone is detected, while administration of saline or whole blood may be recommend if low blood volume is identified as a most probable
20 cause of the predicted future hypotension event.

Referring to Figure 2A, Figure 2A shows an exemplary implementation for sensing arterial pressure non-invasively at an extremity of a living subject. Health monitoring system 200A, in Figure 2A, includes hardware unit 202 having ADC 222 and

hypotension prediction software code 210 including predictive weighting module 216. As shown by Figure 2A, the arterial pressure of living subject 230 is detected non-invasively at finger 232 of living subject 230 using hemodynamic sensing cuff 240a. Also shown in Figure 2A are signal 242 received by health monitoring system 200A
5 from hemodynamic sensing cuff 240a, digital hemodynamic data 244 generated by ADC 222 from signal 242, and hypotension profiling parameters 212 including one or more vital sign parameters characterizing vital sign data, obtained through transformation of digital hemodynamic data 244 by hypotension prediction software code 210.

Living subject 230, signal 242, and hemodynamic sensing cuff 240a correspond
10 respectively in general to living subject 130, signal 142, and hemodynamic sensor 140, in Figure 1, and may share any of the characteristics attributed to those corresponding features in the present application. Moreover, hardware unit 202 having ADC 222 and hypotension prediction software code 210 including predictive weighting module 216, in Figure 2A, corresponds in general to hardware unit 102 having ADC 122 and
15 hypotension prediction software code 110 including predictive weighting module 116, in Figure 1, and may share any of the characteristics attributed to that corresponding feature in the present application.

According to the implementation shown in Figure 2A, hemodynamic sensing cuff 240a is designed to sense an arterial pressure of living subject 230 non-invasively at
20 finger 232 of living subject 230. Moreover, as shown in Figure 2A, hemodynamic sensing cuff 240a may take the form of a small, lightweight, and comfortable hemodynamic sensor suitable for extended wear by living subject 230. It is noted that although hemodynamic sensing cuff 240a is shown as a finger cuff, in Figure 2A, in

other implementations, hemodynamic sensing cuff 240a may be suitably adapted as a wrist, ankle, or toe cuff for attachment to living subject 230.

It is further noted that the advantageous extended wear capability described above for hemodynamic sensing cuff 240a when implemented as a finger cuff may also
5 be attributed to wrist, ankle, and toe cuff implementations. As a result, hemodynamic sensing cuff 240a may be configured to provide substantially continuous beat-to-beat monitoring of the arterial pressure of living subject 230 over an extended period of time, such as minutes or hours, for example.

Continuing to Figure 2B, Figure 2B shows an exemplary implementation for
10 performing minimally invasive detection of arterial pressure of a living subject. As shown by Figure 2B, the arterial pressure of living subject 230 is detected via minimally invasive hemodynamic sensor 240b. It is noted that the features shown in Figure 2B and identified by reference numbers identical to those shown in Figure 2A correspond respectively to those previously described features, and may share any of the
15 characteristics attributed to them above. It is further noted that hemodynamic sensor 240b corresponds in general to hemodynamic sensor 140, in Figure 1, and may share any of the characteristics attributed to that corresponding feature in the present application.

According to the implementation shown in Figure 2B, hemodynamic sensor 240b is designed to sense an arterial pressure of living subject 230 in a minimally invasive
20 manner. For example, hemodynamic sensor 240b may be attached to living subject 230 via a radial arterial catheter inserted into an arm of living subject 230. Alternatively, and although not explicitly represented in Figure 2B, in another implementation, hemodynamic sensor 240b may be attached to living subject 230 via a femoral arterial

catheter inserted into a leg of living subject 230. Like non-invasive hemodynamic sensing cuff 240a, in Figure 2A, minimally invasive hemodynamic sensor 240b, in Figure 2B, may be configured to provide substantially continuous beat-to-beat monitoring of the arterial pressure of living subject 230 over an extended period of time, such as minutes or hours, for example.

Moving now to Figure 3, Figure 3 shows an exemplary system and a computer-readable non-transitory medium including instructions enabling performance of predictive weighting of hypotension profiling parameters. System 300, in Figure 3, includes hardware unit 302 including system processor 304, system memory 306, and display 326. Display 326 may take the form of a liquid crystal display (LCD), a light-emitting diode (LED) display, an organic light-emitting diode (OLED) display, or another suitable display screen that performs a physical transformation of signals to light. System 300 including hardware unit 302 having system processor 304 and system memory 306 corresponds in general to health monitoring system 100 including hardware unit 102 having system processor 104 and system memory 106, and may share any of the characteristics attributed to that corresponding feature in the present application. That is to say, system 302 may be configured to provide user interface 120 and/or sensory alarm 128 using display 326.

Also shown in Figure 3 is computer-readable non-transitory medium 318 having hypotension prediction software code 310 including predictive weighting module 316 stored thereon. The expression “computer-readable non-transitory medium,” as used in the present application, refers to any medium, excluding a carrier wave or other transitory signal, that provides instructions to system processor 304 of hardware unit

302. Thus, a computer-readable non-transitory medium may correspond to various types of media, such as volatile media and non-volatile media, for example. Volatile media may include dynamic memory, such as dynamic random access memory (dynamic RAM), while non-volatile memory may include optical, magnetic, or electrostatic storage devices. Common forms of computer-readable non-transitory media include, for example, optical discs, RAM, programmable read-only memory (PROM), erasable PROM (EPROM), and FLASH memory.

According to the implementation shown in Figure 3, computer-readable non-transitory medium 318 provides hypotension prediction software code 310 including predictive weighting module 316 for execution by system processor 304. Hypotension prediction software code 310, when executed by system processor 304, instantiates a hypotension prediction software code corresponding to hypotension prediction software code 110/210 including predictive weighting module 116/216, in Figure 1/2, and capable of performing all of the operations performed by that corresponding feature and described in the present application.

Example implementations of the present inventive concepts will be further described below with reference to Figure 4 and Figure 5. Figure 4 presents flowchart 460 outlining an exemplary method for use by a health monitoring system to perform predictive weighting of hypotension profiling parameters, while Figure 5 shows a trace of an arterial pressure waveform including exemplary indicia corresponding to the probability of future hypotension in a living subject. The method outlined in flowchart 460 can be performed using hypotension prediction software code 110/210/310 including predictive weighting module 116/216/316 described above.

Flowchart 460 begins with obtaining by hypotension prediction software code 110/210/310 executed by system processor 104/304, digital hemodynamic data 144/244 converted, by ADC 122/222, from signal 142/242 received from hemodynamic sensor 140/240a/240b (action 461). In one implementation, for example, hemodynamic sensor
5 140/240a/240b may be used to sense an arterial pressure of living subject 130/230 at an extremity of living subject 130/230, and to determine a central arterial pressure of living subject 130/230 based on the sensed arterial pressure.

Hardware unit 102/202/302 of system 100/200A/200B/300 may be configured to receive the determined central arterial pressure of living subject 130/230 as signal
10 142/242, which may be received as analog signals. In such an implementation, ADC 122/222 is used to convert signal 142/242 into digital hemodynamic data 144/244. It is noted that in other implementations, hardware unit 102/202/302 can be configured to determine the central arterial pressure of living subject 130/230 based on a peripheral or brachial arterial pressure, for example, sensed by hemodynamic sensor 140/240a/240b
15 and received by hardware unit 102/202/302 as signal 142/242.

Referring to diagram 500, in Figure 5, digital hemodynamic data 144/244 may include various indicia predictive of a future hypotension event for living subject 130/230 and extracted from arterial pressure waveform 580, which may be a central arterial pressure waveform of living subject 130/230. Diagram 500 shows exemplary
20 indicia 582, 584, 586, and 588, corresponding respectively to the start of a heartbeat, the maximum systolic pressure marking the end of systolic rise, the presence of the diastolic notch marking the end of systolic decay, and the diastole of the heartbeat of living subject 130/230. Also shown by diagram 500 is exemplary slope 590 of arterial pressure

waveform 580. It is noted that slope 590 is merely representative of multiple slopes that may be measured at multiple locations along arterial pressure waveform 580.

In addition to the indicia 582, 584, 586, and 588 of arterial pressure waveform 580 per se, the behavior of arterial pressure waveform 580 during the intervals between those indicia may also be used as indicia predictive of future hypotension for living
5 subject 130/240. For example, the interval between the start of the heartbeat at indicia 582 and the maximum systolic pressure at indicia 584 marks the duration of the systolic rise (hereinafter "systolic rise 582-584"). The systolic decay of arterial pressure waveform 580 is marked by the interval between the maximum systolic pressure at
10 indicia 584 and the dicrotic notch at indicia 586 (hereinafter "systolic decay 584-586"). Together, systolic rise 582-584 and systolic decay 584-586 mark the entire systolic phase (hereinafter "systolic phase 582-586"), while the interval between the dicrotic notch at indicia 586 and the diastole at indicia 588 mark the diastolic phase of arterial pressure waveform 580 (hereinafter "diastolic phase 586-588").

Also of potential diagnostic interest is the behavior of arterial pressure waveform
15 580 in the interval from the maximum systolic pressure at indicia 584 to the diastole at indicia 588 (hereinafter "interval 584-588"), as well as the behavior of arterial pressure waveform 580 from the start of the heartbeat at indicia 582 to the diastole at indicia 588 (hereinafter "heartbeat interval 582-588"). The behavior of arterial pressure waveform
20 580 during intervals: 1) systolic rise 582-584, 2) systolic decay 584-586, 3) systolic phase 582-586, 4) diastolic phase 586-588, 5) interval 584-588, and 6) heartbeat interval 582-588 may be determined by measuring the area under the curve of arterial pressure waveform 580 and the standard deviation of arterial pressure waveform 580 in each of

those intervals, for example. The respective areas and standard deviations measured for intervals 1, 2, 3, 4, 5, and 6 above (hereinafter “intervals 1-6”) may serve as additional indicia predictive of future hypotension for living subject 130/240.

Flowchart 460 continues with obtaining, by hypotension prediction software code 5 110/210/310 executed by system processor 104/304, one or more vital sign parameters characterizing vital sign data, i.e., characterizing vital sign data of living subject 130/230, from digital hemodynamic data 144/244 (action 462). As noted above, digital hemodynamic data 144/244 may include any or all of indicia 582, 584, 586, 588, and 590. In addition, digital hemodynamic data 144/244 may further include the respective 10 areas and standard deviations measured for intervals 1-6 of arterial pressure waveform 580, as discussed above. According to the exemplary implementations shown in Figures 1, 2A, and 2B, digital hemodynamic data 144/244 is received by hypotension prediction software code 110/210/310 from ADC 122/222.

The one or more vital sign parameters characterizing vital sign data may include 15 stroke volume, heart rate, respiration, and cardiac contractility, to cite a few examples. Moreover, the one or more vital sign parameters characterizing vital sign data may include a variety of different types of parameters found to be predictive of future hypotension. For instance, the one or more vital sign parameters characterizing vital sign data may include any or all of mean arterial pressure (MAP), baroreflex sensitivity 20 measures, hemodynamic complexity measures, and frequency domain hemodynamic features.

Baroreflex sensitivity measures quantify the relationship between complementary physiological processes. For example, a decrease in blood pressure in a healthy living

subject is typically compensated by an increase in heart rate and/or an increase in peripheral resistance. The baroreflex sensitivity measures that may be included in the one or more vital sign parameters characterizing vital sign data correspond to the degree to which living subject 130/230 is responding appropriately to normal physiological variations.

Hemodynamic complexity measures quantify the amount of regularity in cardiac measurements over time, as well as the entropy, i.e., the unpredictability of fluctuations in cardiac measurements over time. For example, the present inventors have realized that unpredictable cardiac fluctuations are a normal phenomenon associated with health. Perhaps counterintuitively, very low entropy, in other words a high degree of regularity in cardiac measurements over time and the substantial absence of unpredictable fluctuations, can be a significant warning sign of an impending hypotension event. Frequency domain hemodynamic features quantify various measures of cardiac performance as a function of frequency rather than time.

Flowchart 460 continues with deriving differential parameters based on the one or more vital sign parameters characterizing vital sign data (action 463). Obtaining differential parameters based on the one or more vital sign parameters (hereinafter “the differential parameters”) may be performed by hypotension prediction software code 110/210/310 executed by system processor 104/304. The differential parameters may be derived by determining the variations of one or more vital sign parameters with respect to time, with respect to frequency, or with respect to other parameters from among one or more vital sign parameters, for example. As a result, each of one or more vital sign

parameters may give rise to one, two, or several differential parameters included among hypotension profiling parameters 112/212.

For example, the differential parameter stroke volume variation (SVV) may be derived based on changes in the parameter stroke volume (SV) as a function of time and/or as a function of sampling frequency. Analogously, changes in mean arterial pressure (Δ MAP) can be derived as a differential parameter with respect to time and/or sampling frequency, and so forth. As a further example, changes in mean arterial pressure with respect to time can be derived by subtracting the average of the mean arterial pressure over the past 5 minutes, over the past 10 minutes, and so on from the current value of the mean arterial pressure.

Flowchart 460 continues with generating combinatorial parameters using the one or more vital sign parameters and the differential parameters (action 464). Generation of such combinatorial parameters (hereinafter “the combinatorial parameters”) may be performed by hypotension prediction software code 110/210/310 executed by system processor 104/304. For example, the combinatorial parameters may be generated using the one or more vital sign parameters and the differential parameters by generating a power combination of a subset of the one or more vital sign parameters and the differential parameters. It is noted that, as used in the present application, the characterization “a subset of the one or more vital sign parameters and the differential parameters” refers to a subset that includes at least one of the one or more vital sign parameters and/or at least one of the differential parameters.

As a specific example, each of the combinatorial parameters may be generated as a power combination of three parameters, which may be randomly or purposefully

selected, from among the one or more vital sign parameters characterizing vital sign data and/or the differential parameters. Each of those three parameters selected from among the one or more vital sign parameters and/or the differential parameters can be raised to an exponential power and can be multiplied with, or added to, the other two parameters
 5 analogously raised to an exponential power. The exponential power to which each of the three parameters selected from the one or more vital sign parameters and/or the differential parameters is raised may be, but need not be, the same.

In some implementations, for example, generation of the combinatorial parameters may be performed using a predetermined and limited integer range of
 10 exponential powers. For instance, in one such implementation, the exponential powers used to generate the combinatorial parameters may be integer powers selected from among negative two, negative one, zero, one, and two (-2, -1, 0, 1, 2). Thus, each combinatorial parameter may take the form:

$$X = Y_1^a * Y_2^b * \dots * Y_n^c \quad (\text{Equation 1})$$

15 where each **Y** is one of one or more vital sign parameters characterizing vital sign data or one of the differential parameters, **n** is any integer greater than two, and each of **a**, **b**, and **c** may be any one of -2, -1, 0, 1, and 2, for example. In one implementation, Equation 1 may be applied to substantially all possible power combinations of the one or more vital sign parameters, the differential parameters, and the one or more vital sign
 20 parameters with the differential parameters, subject to the predetermined constraints discussed above, such as the value of **n** and the numerical range from which the exponential powers may be selected.

Hypotension profiling parameters 112/212 include one or more vital sign parameters characterizing vital sign data, the differential parameters and the combinatorial parameters. Thus, actions 462, 463, and 464 result in transformation of digital hemodynamic data 144/244 to hypotension profiling parameters 112/212. That is
5 to say, digital hemodynamic data 144/244 is transformed to hypotension profiling parameters 112/212 using hypotension prediction software code 110/210/310, executed by system processor 104/304, by identifying one or more vital sign parameters characterizing vital sign data, based on digital hemodynamic data 144/244, obtaining the differential parameters based on one or more vital sign parameters, and generating the
10 combinatorial parameters using one or more of vital sign parameters and the differential parameters. An exemplary but non-exhaustive table of hypotension profiling parameters 112/212, as well as exemplary sampling criteria associated with their determination, is provided as Appendix A of the present application.

Flowchart 460 continues with determining, by hypotension prediction software
15 code 110/210/310 using predictive weighting module 116/216/316 and executed by system processor 104/304, a risk score corresponding to the probability of a future hypotension event for living subject 130/230 based on a weighted combination of hypotension profiling parameters 112/212 (action 465). In other words, the risk score corresponding to the probability of a future hypotension event for living subject 130/230
20 is determined based on the one or more vital sign parameters characterizing vital sign data, the differential parameters and the combinatorial parameters.

It is noted that in implementations in which one or more vital sign parameters characterizing vital sign data includes the MAP of living subject 130/230, the weighting

applied to the MAP may depend on the value of the MAP itself. Where the MAP is very high, the MAP may be a relatively unreliable predictor of hypotension and may consequently be very lightly weighted. That is to say, where the MAP exceeds a predetermined upper limit threshold, for example, the weighting applied to the MAP may be such that the weighted combination of hypotension profiling parameters 112/212 results in the MAP being substantially disregarded in determination of the risk score. By contrast, in other cases, the MAP may dominate the determination of the risk score.

It is emphasized that the risk score of living subject 130/230 is determined based on a weighted combination of hypotension profiling parameters 112/212, which in turn are derived from signal 142/242 of living subject 130/230 received from hemodynamic sensor 140/240a/240b. Consequently, according to the inventive concepts disclosed by the present application, system processor 104/304 of health monitoring system 100/200A/200B/300 is configured to execute hypotension prediction software code 110/210/310 to determine the risk score of living subject 130/230 without comparison with data corresponding to hypotension in other living subjects. In other words, hypotension prediction software code 110/210/310 determines the risk score of living subject 130/230 based on quantities derived from digital hemodynamic data 144/244, i.e., hypotension profiling parameters 112/212, without reference to a hypotension patient database storing information regarding hypotension in patients other than living subject 130/230.

By way merely of example, the risk score may be expressed as:

$$\text{Risk Score} = 1/(1 + e^{-d}) \quad (\text{Equation 2})$$

Where:

$$\begin{aligned} A = & c_0 + c_1 \times v_1 + c_2 \times v_2 + c_3 \times v_3 + c_4 \times v_4 + c_5 \times v_5 + c_6 \times v_6 \\ & + c_7 \times v_7^2 \times v_8^2 \times v_9^{-2} + c_8 \times v_2^2 \times v_{10} \times v_{11}^{-1} + c_9 \times \Delta(v_{12}^2 \times v_{13}^2 \times v_{14}) \\ & + c_{10} \times \Delta(v_{15}^2 \times v_1 \times v_{16}^{-1}) + c_{11} \times \Delta(v_{17}^2 \times v_{18}^2 \times v_{19}^{-2}) \end{aligned}$$

And where:

v_1 = CWI, the cardiac work indexed by patient's body surface area;

5 v_2 = MAPavg, the averaged mean arterial pressure;

v_3 = Δ MAPavg, the change of averaged mean arterial pressure when compared to initial values;

v_4 = avgSysDec, the averaged pressure at the decay portion of the systolic phase;

10 v_5 = Δ Sys, the change of systolic pressure when compared to initial values;

v_6 = ppAreaNor, the normalized area under the arterial pressure waveform;

v_7 = biasDia, the bias of the diastolic slope;

v_8 = CW, the cardiac work;

v_9 = mapDnlocArea, the area under the arterial pressure waveform, between

15 first instance of MAP and the dicrotic notch;

v_{10} = SWcomb, the stroke work;

v_{11} = ppArea, the area under the arterial pressure waveform;

v_{12} = decAreaNor, the normalized area of the decay phase;

v_{13} = slopeSys, the slope of the systolic phase;

v_{14} = Cwk, the Windkessel compliance;

v_{15} = sys_rise_area_nor, the normalized area under the systolic rise phase;

v_{16} = pulsepres, the pulse pressure;

5 v_{17} = avg_sys, the averaged pressure of the systolic phase;

v_{18} = dpdt2, the maximum value of the second order derivative of the pressure waveform;

v_{19} = dpdt, the maximum value of the first order derivative of the pressure waveform; and

10 Δ = the change of the value when compared to its initial value

$c_0, c_1, \dots, c_{11}$ are constant coefficients.

In some implementations, the risk score may be expressed as a fraction, as represented by Equation 2. However, in other implementations, the risk score may be converted to a percentage risk score between zero percent and one hundred percent.

15 Flowchart 460 can conclude with invoking, by hypotension prediction software code 110/210/310 executed by system processor 104/304, sensory alarm 128 if the risk score satisfies a predetermined risk criterion (action 466). As shown in Figure 1, for example, hypotension prediction software code 110/210/310 may be configured to provide an output to user interface 120 on display 126/326 for displaying the risk score,
20 and/or for invoking sensory alarm 128. As further shown in Figure 1, in some implementations, the output of hypotension prediction software code 110/210/310 may

be processed using DAC 124 to convert digital signals into analog signals for presentation via user interface 120.

The predetermined risk criterion may be based on the value of the risk score, on the trend of the risk score over a time interval, or both. For example, where the risk score is expressed as a percentage between zero and one hundred, having the risk score exceed a threshold of eighty-five percent, for instance, may cause sensory alarm 128 to be invoked immediately. Alternatively, or in addition, a lower risk score may cause sensory alarm 128 to be invoked if it exceeds a predetermined threshold over the entirety of a predetermined time period.

Thus, for example, while a risk score of eighty five percent may cause sensory alarm 128 to be invoked immediately, a risk score of eighty percent may cause sensory alarm 128 to be invoked after several seconds at that level, such as ten to thirty seconds in which the risk score is continuously between eighty and eighty five percent, for example. By analogy, a still lower risk score may cause sensory alarm 128 to be invoked if that risk score is maintained continuously for one or more minutes. In yet another implementation, the risk score may cause sensory alarm 128 to be invoked if it meets or exceeds a predetermined value a predetermined number of times over a predetermined time period. For example, having the risk score exceed seventy five percent three times over a five minute interval may cause sensory alarm 128 to be invoked.

As noted above by reference to Figure 1, sensory alarm 128 may be implemented as one or more of a visual alarm, an audible alarm, and a haptic alarm. For example, when implemented to provide a visual alarm, sensory alarm 128 may be invoked as flashing and/or colored graphics shown by user interface 120 on display 126, and/or may

include displaying the risk score via user interface 120 on display 126/326. When implemented to provide an audible alarm, sensory alarm 128 may be invoked as any suitable warning sound, such as a siren or repeated tone. Moreover, when implemented to provide a haptic alarm, sensory alarm 128 may cause hardware unit 102/302 to vibrate
5 or otherwise deliver a physical impulse perceptible to user 150.

Although not included among the actions outlined by flowchart 460, in some implementations, the present method may include identifying, by hypotension prediction software code 110/210/310 executed by system processor 104/304, a most probable cause of the future hypotension event of living subject 130/230. For example, and as
10 noted above, based on indicia included in digital hemodynamic data 144/244, hypotension prediction software code 110/210/310 may be used to identify poor vascular tone, low blood volume, or reduced cardiac contractility, to name a few exemplary causes, as a most probable cause of a predicted future hypotension event.

In addition, in some implementations, the present method may include
15 recommending, by hypotension prediction software code 110/210/310 executed by system processor 104/304, a medical intervention for preventing the future hypotension event of living subject 130/230. With respect to poor vascular tone or low blood volume, for example, administration of a vasoconstrictor may be recommended if poor vascular tone is detected, while administration of saline or whole blood may be recommend if low
20 blood volume is identified as a most probable cause of the predicted future hypotension event.

Thus, by converting data received from a hemodynamic sensor to digital hemodynamic data of a living subject, and by transforming the digital hemodynamic data

to multiple hypotension profiling parameters, the present solution employs a powerful multivariate model for predicting future hypotension. The solution disclosed by the present application then determines a risk score corresponding to the probability of a future hypotension event for the living subject based on a weighed combination of the multiple hypotension profiling parameters. In addition, by invoking a sensory alarm if the risk score satisfies a predetermined risk criterion, the present application discloses a solution that provides an early warning of a future hypotension event for the living subject, thereby advantageously enabling health care workers to prepare a timely and effective intervention.

From the above description it is manifest that various techniques can be used for implementing the concepts described in the present application without departing from the scope of those concepts. Moreover, while the concepts have been described with specific reference to certain implementations, a person of ordinary skill in the art would recognize that changes can be made in form and detail without departing from the scope of those concepts. As such, the described implementations are to be considered in all respects as illustrative and not restrictive. It should also be understood that the present application is not limited to the particular implementations described herein, but many rearrangements, modifications, and substitutions are possible without departing from the scope of the present disclosure.

APPENDIX A

<u>Hypotension Profiling Parameter Description</u> <u>Criteria</u>	<u>Sampling</u>
1. TR_bp_dia: Diastolic pressure	20 sec. average
2. TR_c_wk: The Windkessel Compliance (based on the Langewooters paper)	20 sec. average
3. TR_CO_disp: Cardiac output	20 sec. average
4. TR_CO_hsi: Cardiac output computed with a heavily weighted multivariate model based on hyperdynamic conditions	20 sec. average
5. TR_COaccum_avg: Cardiac output – 5 min. average	5 min. average
6. TR_dia_area_nodia: Area under the arterial pressure waveform from the dicrotic notch to the start of the next beat with subtracted diastolic pressure	20 sec. average
7. TR_dpdt_var: Variability in maximum of the first derivative	20 sec. average
8. TR_dpdt2_var: Variability in maximum of the second derivative	20 sec. average
9. TR_HR_avg_disp: Heart rate – 5 min. average	5 min. average
10. TR_K_avg_fp_tp: Multivariate classification model to detect the likelihood of a false positive in the prediction of K_avg_dm	20 sec. average
11. TR_t_sys_rise_var: Variability in TR_t_sys_rise	20 sec. average

12. TR_K_avg_hyp_w:	Vascular tone computed from a weighted multivariate model derived from severe hyperdynamic conditions	20 sec. average
13. TR_K_avg_lco:	Multivariate classification model to detect low flow conditions	20 sec. average
14. TR_kmult:	Arterial tone estimate	20 sec. average
15. TR_kmult_fp_tp:	K_avg_fp_tp – 20 sec. Average	20 sec. average
16. TR_kurt:	The kurtosis of the arterial pressure waveform within a beat	20 sec. average
17. TR_kurt_var:	Variability in the kurtosis of the arterial pressure waveform within a beat	20 sec. average
18. TR_sku:	Skewness of the arterial pressure waveform within a beat	20 sec. average
19. TR_sku_var:	Variability in TR_sku	20 sec. average
20. TR_sku2:	Skewness of the 20 sec. reconstructed arterial pressure waveform	20 sec. average
21. TR_slope_dia:	Diastolic slope	20 sec. average
22. TR_slope_dia_var:	Variability in the diastolic slope	20 sec. average
23. TR_slope_sys:	Slope of the systolic rise	20 sec. average
24. TR_SVV_avg_disp:	Stroke volume variation (SVV) – 5 min. average	5 min. average
25. TR_SVV_disp:	SVV sensed by hemodynamic sensor 140/240a/240b	20 sec. average

- | | | |
|--------------------|---|--------------------|
| 26. TR_SVV_resp: | SVV computed with the detection of the respiratory cycles in the signal | 20 sec.
average |
| 27. TR_t_dec_var: | Variability in time from systolic maximum to start of next heart beat | 20 sec.
average |
| 28. TR_t_sys: | Duration of the systolic phase from the start of the heart beat to the dicrotic notch | 20 sec.
average |
| 29. TR_t_sys_dec: | Time from the systolic maximum to the dicrotic notch | 20 sec.
average |
| 30. TR_t_sys_rise: | Time from the start of the heart beat to the systolic maximum | 20 sec.
average |

CLAIMS

What is claimed is:

- 5 1. A system for monitoring health of a living subject, the system comprising:
a hardware unit including a hardware processor, an analog-to-digital converter
(ADC), and a system memory;
a hypotension prediction software code including a predictive weighting module
stored in the system memory;
10 a hemodynamic sensor coupled to the hardware unit; and
a sensory alarm;
wherein the hardware processor is configured to execute the hypotension
prediction software code to:
obtain a digital hemodynamic data converted, by the ADC, from a
15 signal received from the hemodynamic sensor;
obtain one or more vital sign parameters characterizing vital sign
data from the digital hemodynamic data;
derive differential parameters based on the one or more vital sign
parameters characterizing the vital sign data;
20 generate combinatorial parameters using the one or more vital sign
parameters characterizing the vital sign data and the differential
parameters;

determine, using the predictive weighting module, a risk score corresponding to a probability of a future hypotension event for the living subject based on a weighted combination of a plurality of hypotension profiling parameters including the one or more vital sign parameters characterizing vital sign data, the differential parameters and the combinatorial parameters; and

invoke the sensory alarm if the risk score satisfies a predetermined risk criterion.

2. The system of claim 1, wherein the predetermined risk criterion is based on at least one of a value of the risk score and a trend of the risk score over a time interval.

3. The system of claim 1, wherein the weighted combination of the plurality of hypotension profiling parameters results in a mean arterial pressure (MAP) of the living subject being substantially disregarded in determination of the risk score.

4. The system of claim 1, wherein the weighted combination of the plurality of hypotension profiling parameters results in a MAP of the living subject substantially dominating determination of the risk score.

5. The system of claim 1, wherein the plurality of hypotension profiling parameters comprise at least one of:

905038_1 CCHDM-8773WO01

baroreflex sensitivity measures;
hemodynamic complexity measures;
frequency domain hemodynamic features;
nonlinear combinations of hemodynamic features; and
5 variations in hemodynamic features.

6. The system of claim 1, wherein the hardware processor is further configured to execute the hypotension prediction software code to identify a most probable cause of the future hypotension event.

7. The system of claim 6, wherein the hardware processor is further configured to execute the hypotension prediction software code to recommend a medical intervention for preventing the future hypotension event.

8. A method for use by a system for monitoring health of a living subject, the system comprising a hemodynamic sensor, a sensory alarm, and a hardware unit including a hardware processor, an analog-to-digital converter (ADC), and a hypotension prediction software code including a predictive weighting module stored in a system memory, the method comprising:

obtaining, by the hypotension prediction software code executed by the hardware processor, a digital hemodynamic data converted, by the ADC, from a signal received from the hemodynamic sensor;

obtaining, by the hypotension prediction software code executed by the hardware processor, one or more vital sign parameters characterizing vital sign data from the digital hemodynamic data;

deriving, by the hypotension prediction software code executed by the hardware processor, differential parameters based on the one or more vital sign parameters characterizing vital sign data;

generating, by the hypotension prediction software code executed by the hardware processor, combinatorial parameters using the one or more vital sign parameters characterizing vital sign data and the differential parameters;

determining, by the hypotension prediction software code using the predictive weighting module and executed by the hardware processor, a risk score corresponding to the probability of a future hypotension event for the living subject based on a weighted combination of a plurality of hypotension profiling parameters including the one or more vital sign parameters characterizing vital sign data, the differential parameters and the combinatorial parameters; and

invoking, by the hypotension prediction software code executed by the hardware processor, the sensory alarm if the risk score satisfies a predetermined risk criterion.

9. The method of claim 8, wherein the predetermined risk criterion is based on at least one of a value of the risk score and a trend of the risk score over a time interval.

10. The method of claim 8, wherein the weighted combination of the plurality of hypotension profiling parameters results in a mean arterial pressure (MAP) of the living subject being substantially disregarded in determination of the risk score.

5 11. The method of claim 8, wherein the weighted combination of the plurality of hypotension profiling parameters results in a MAP of the living subject substantially dominating determination of the risk score.

12. The method of claim 8, wherein the plurality of hypotension profiling
10 parameters comprise at least one of:
baroreflex sensitivity measures;
hemodynamic complexity measures;
frequency domain hemodynamic features;
nonlinear combinations of hemodynamic features; and
15 variations in hemodynamic features.

13. The method of claim 8, further comprising identifying, by the
hypotension prediction software code executed by the hardware processor, a most
probable cause of the future hypotension event.
20

14. The method of claim 13, further comprising recommending, by the
hypotension prediction software code executed by the hardware processor, a medical
intervention for preventing the future hypotension event.

905038_1 CCHDM-8773WO01

15. A computer-readable non-transitory medium having stored thereon instructions, which when executed by a hardware processor, instantiate a method comprising:

5 obtaining a digital hemodynamic data converted, by an analog-to-digital converter (ADC), from a signal received from the hemodynamic sensor;

obtaining one or more vital sign parameters characterizing vital sign data from the digital hemodynamic data;

deriving differential parameters based on the one or more vital sign parameters
10 characterizing vital sign data;

generating, by the hypotension prediction software code executed by the hardware processor, combinatorial parameters using the one or more vital sign parameters characterizing vital sign data and the differential parameters;

determining a risk score corresponding to the probability of a future hypotension
15 event for a living subject based on a weighted combination of a plurality of hypotension profiling parameters including the one or more vital sign parameters characterizing vital sign data, the differential parameters and the combinatorial parameters; and

invoking a sensory alarm if the risk score satisfies a predetermined risk criterion.

20 16. The computer-readable non-transitory medium of claim 15, wherein the predetermined risk criterion is based on at least one of a value of the risk score and a trend of the risk score over a time interval.

17. The computer-readable non-transitory medium of claim 15, wherein the weighted combination of the plurality of hypotension profiling parameters results in a mean arterial pressure (MAP) of the living subject being substantially disregarded in determination of the risk score.

5

18. The computer-readable non-transitory medium of claim 15, wherein the weighted combination of the plurality of hypotension profiling parameters results in a MAP of the living subject substantially dominating determination of the risk score.

10 19. The computer-readable non-transitory medium of claim 15, wherein the plurality of hypotension profiling parameters comprise at least one of:

baroreflex sensitivity measures;

hemodynamic complexity measures;

frequency domain hemodynamic features;

15 nonlinear combinations of hemodynamic features; and

variations in hemodynamic features.

20 20. The computer-readable non-transitory medium of claim 15, further comprising identifying a most probable cause of the future hypotension event.

20

Fig. 1

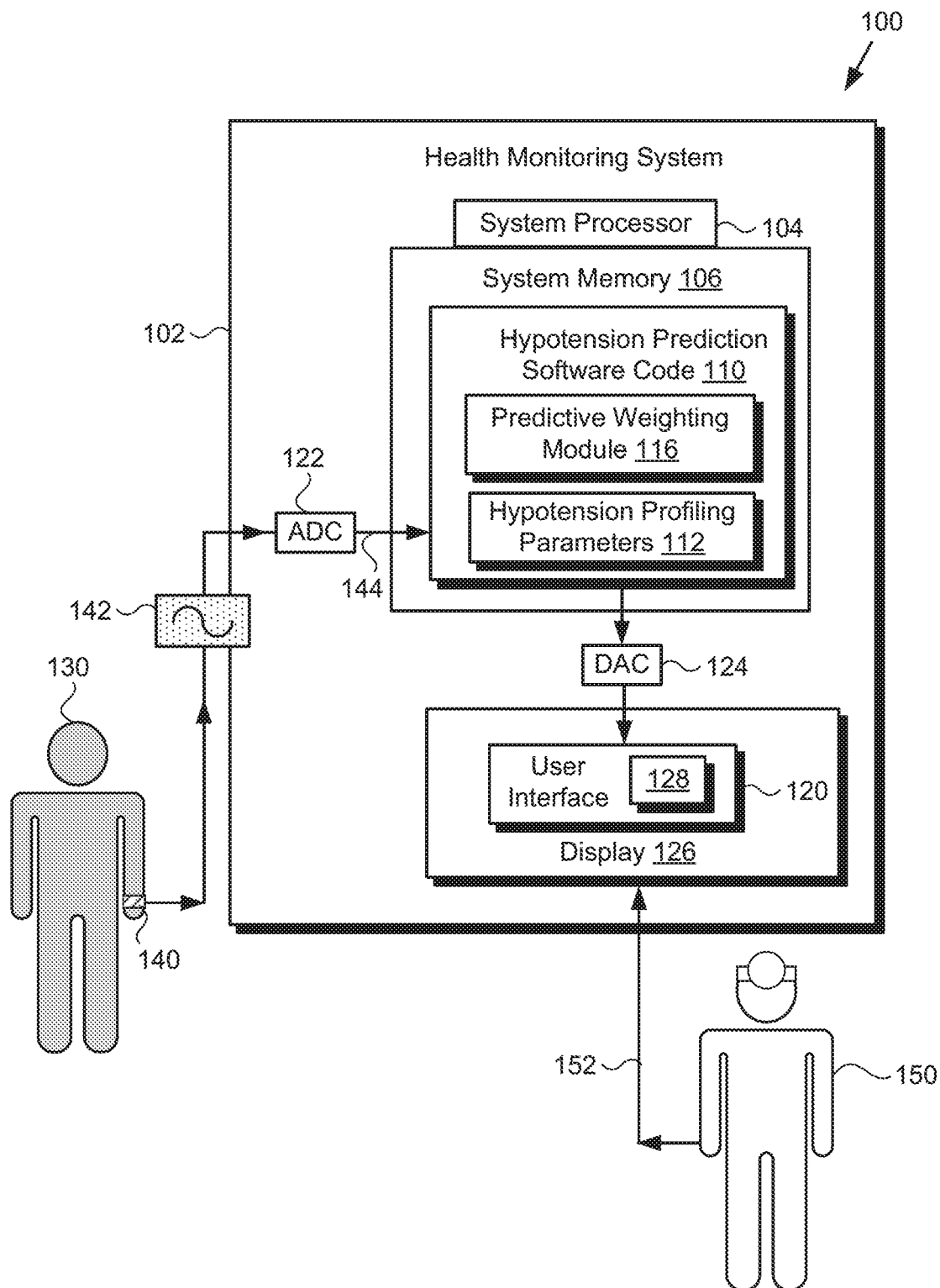


Fig. 2A

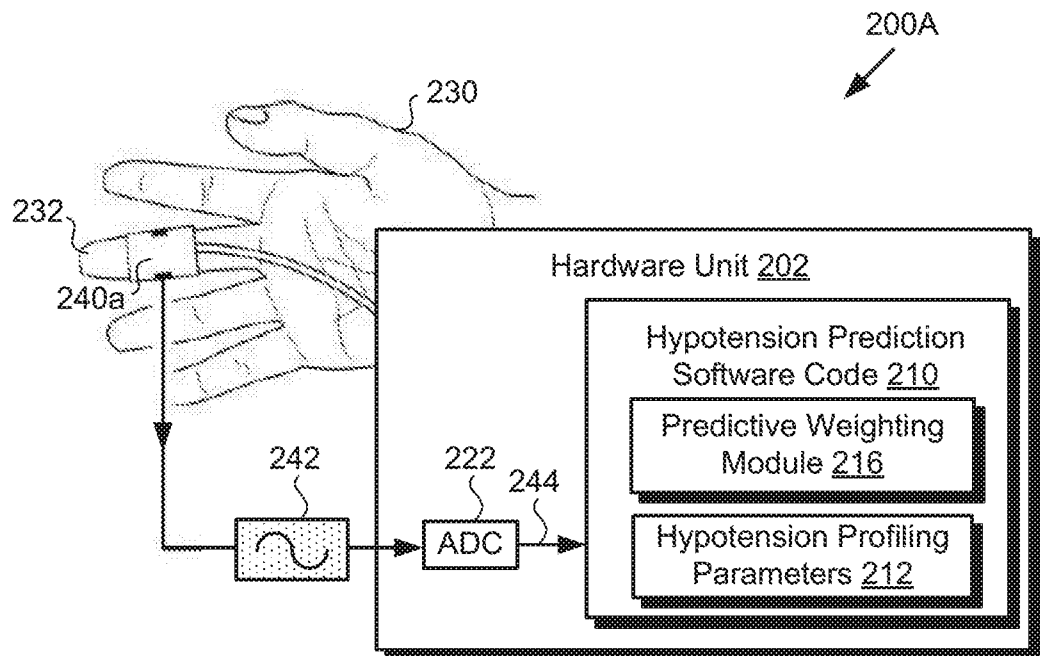


Fig. 2B

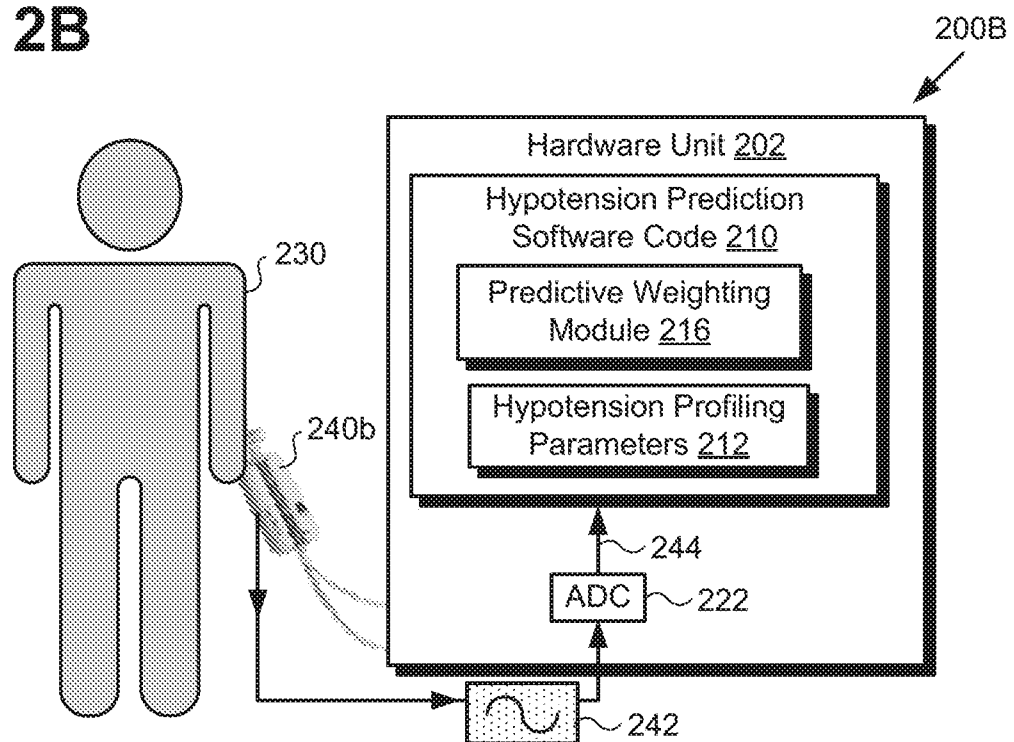


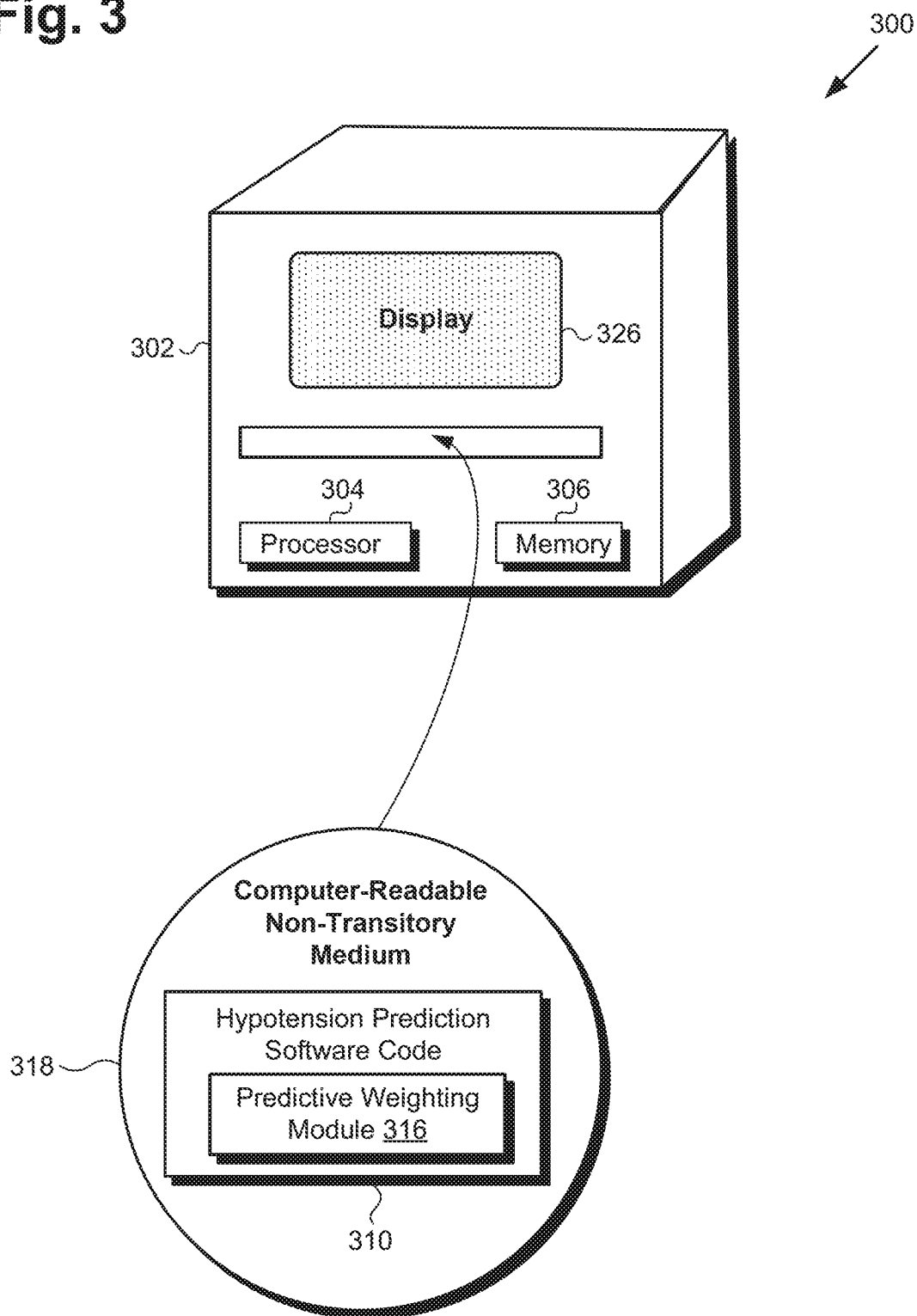
Fig. 3

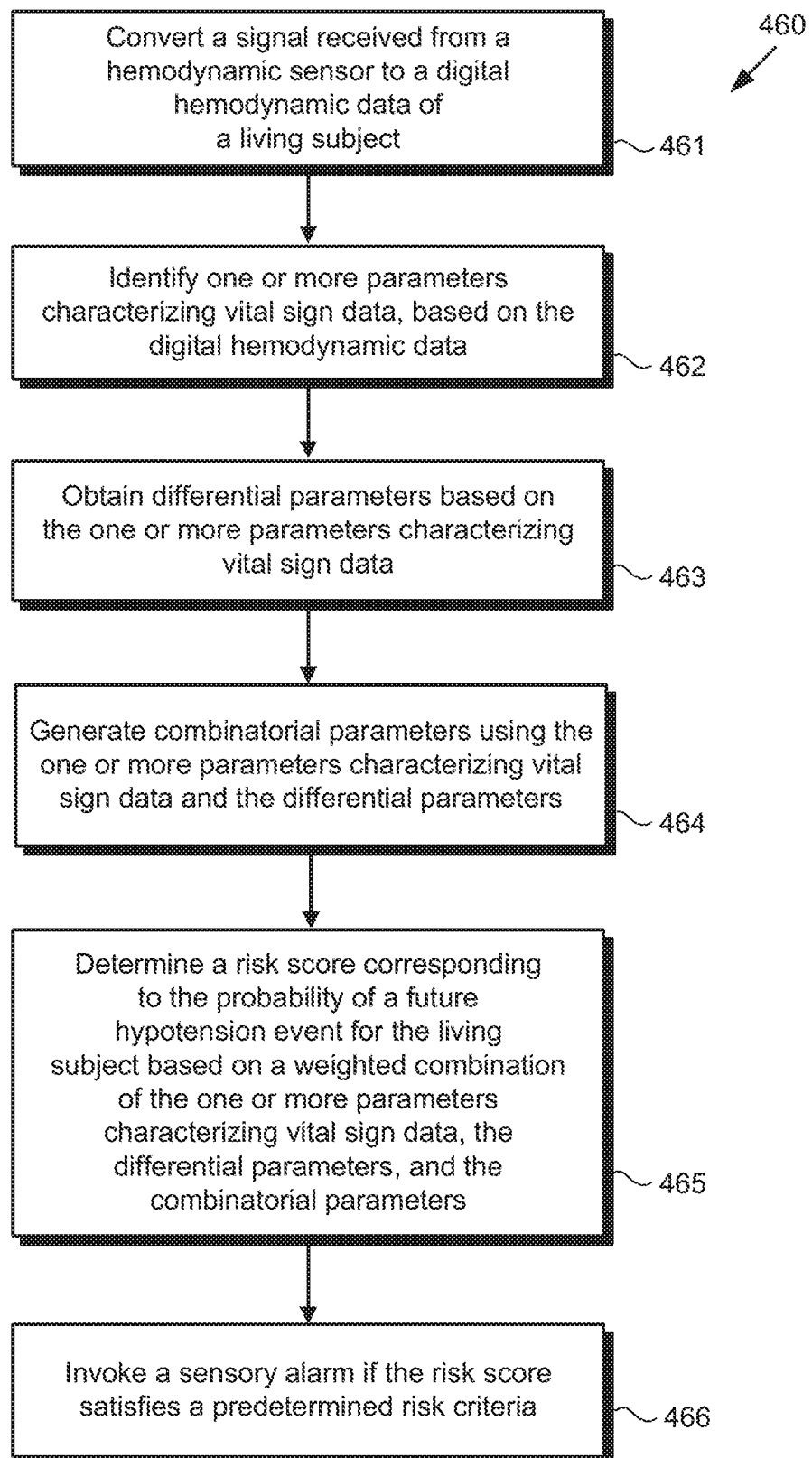
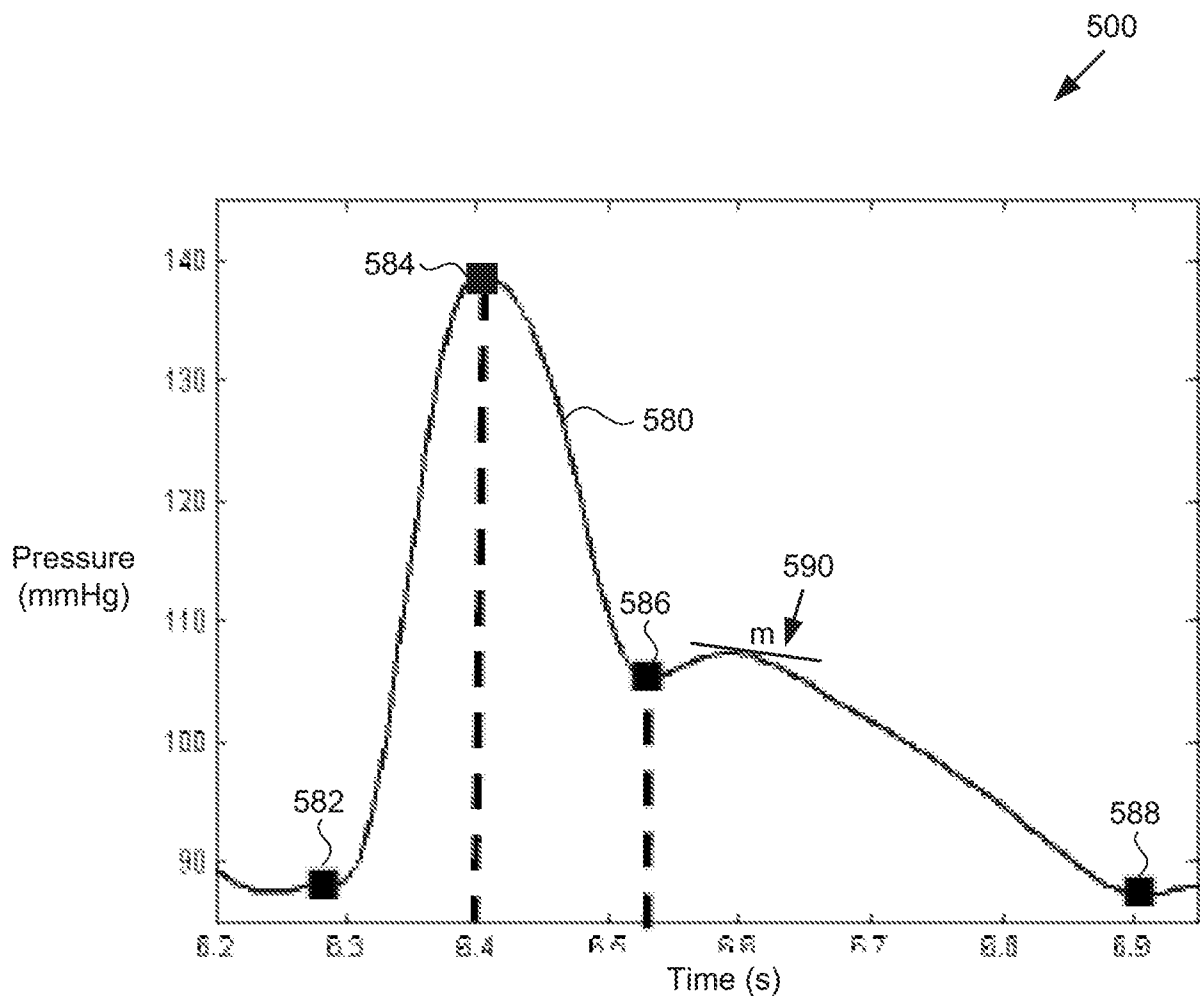
Fig. 4

Fig. 5

INTERNATIONAL SEARCH REPORT

International application No.
PCT/US2017/039974**A. CLASSIFICATION OF SUBJECT MATTER****A61B 5/00(2006.01)i, A61B 5/021(2006.01)i**

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)

A61B 5/00; A61M 1/30; A61B 5/02; A61B 5/0452; A61M 1/14; A61B 5/0205; A61B 5/021

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Korean utility models and applications for utility models

Japanese utility models and applications for utility models

Electronic data base consulted during the international search (name of data base and, where practicable, search terms used)

eKOMPASS(KIPO internal) & Keywords: hemodynamic, blood pressure, hypotension, risk, alarm

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
Y	US 2013-0096402 A1 (OLDE et al.) 18 April 2013	1, 2, 5-9, 12-16, 19
A	See paragraphs [50]-[55], [72], [97]-[100], claims 1-5, 36 and figures 1, 8.	, 20 3, 4, 10, 11, 17, 18
Y	US 2014-0364750 A1 (INTELOMEND, INC.) 11 December 2014	1, 2, 5-9, 12-16, 19
A	See paragraph [65] and figure 5.	, 20
A	US 2008-0319332 A1 (SORNMO et al.) 25 December 2008	1-20
A	See paragraphs [48]-[65] and figures 1a, 12.	
A	US 2011-0245631 A1 (GENC) 06 October 2011	1-20
A	See claims 1-4 and figures 1-5.	
A	EP 2730302 A1 (PIONEER CORPORATION) 14 May 2014	1-20
A	See claims 1-7 and figures 1-3.	

☐ Further documents are listed in the continuation of Box C.☒ See patent family annex.

* Special categories of cited documents:

"A" document defining the general state of the art which is not considered to be of particular relevance

"E" earlier application or patent but published on or after the international filing date

"L" document which may throw doubts on priority claim(s) or which is cited to establish the publication date of another citation or other special reason (as specified)

"O" document referring to an oral disclosure, use, exhibition or other means

"P" document published prior to the international filing date but later than the priority date claimed

"T" later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention

"X" document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone

"Y" document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art

"&" document member of the same patent family

Date of the actual completion of the international search

25 August 2017 (25.08.2017)

Date of mailing of the international search report

28 August 2017 (28.08.2017)

Name and mailing address of the ISA/KR

International Application Division

Korean Intellectual Property Office

189 Cheongsa-ro, Seo-gu, Daejeon, 35208, Republic of Korea



Facsimile No. +82-42-481-8578

Authorized officer

KIM, Yeon Kyung

Telephone No. +82-42-481-3325



INTERNATIONAL SEARCH REPORT

Information on patent family members

International application No.

PCT/US2017/039974

Patent document cited in search report	Publication date	Patent family member(s)	Publication date
US 2013-0096402 A1	18/04/2013	EP 2519283 A1 US 2013-0274570 A9 WO 2011-080185 A1	07/11/2012 17/10/2013 07/07/2011
US 2014-0364750 A1	11/12/2014	AU 2014-278194 A1 CA 2915060 A1 EP 3007616 A1 EP 3007616 A4 WO 2014-201183 A1	04/02/2016 18/12/2014 20/04/2016 25/01/2017 18/12/2014
US 2008-0319332 A1	25/12/2008	AU 2006-291593 A1 AU 2006-291593 B2 CA 2622125 A1 CA 2622125 C EP 1926423 A1 EP 1926423 A4 EP 1926423 B1 US 2013-0116587 A1 US 8311619 B2 US 8805487 B2 WO 2007-032732 A1	22/03/2007 24/05/2012 22/03/2007 14/10/2014 04/06/2008 07/04/2010 10/10/2012 09/05/2013 13/11/2012 12/08/2014 22/03/2007
US 2011-0245631 A1	06/10/2011	US 8795186 B2	05/08/2014
EP 2730302 A1	14/05/2014	EP 2730302 A4 EP 2730302 B1 EP 2730302 B8 JP 5620001 B2 JP WO2013-005320 A1 WO 2013-005320 A1	03/12/2014 30/11/2016 19/04/2017 05/11/2014 23/02/2015 10/01/2013

专利名称(译)	预测加权低血压分析参数		
公开(公告)号	EP3481289A1	公开(公告)日	2019-05-15
申请号	EP2017824726	申请日	2017-06-29
[标]申请(专利权)人(译)	爱德华兹生命科学公司		
申请(专利权)人(译)	爱德华生命科学公司		
当前申请(专利权)人(译)	爱德华生命科学公司		
[标]发明人	AL HATIB FERAS JIAN ZHONGPING BUDDI SAI PRASAD		
发明人	AL HATIB, FERAS JIAN, ZHONGPING BUDDI, SAI PRASAD		
IPC分类号	A61B5/00 A61B5/021		
CPC分类号	A61B5/02028 A61B5/02042 A61B5/021 A61B5/7239 A61B5/7275 A61B5/746 G16H50/30		
优先权	62/360088 2016-07-08 US 15/634918 2017-06-27 US		
其他公开文献	EP3481289A4		
外部链接	Espacenet		

摘要(译)

一种系统，其具有处理器从血液动力学传感器获得数字血液动力学数据，从数字血液动力学数据获得表征生命体征数据的一个或多个生命体征参数，基于所述一个或多个生命体征参数导出差分参数，使用所述生命体征参数生成组合参数。一个或多个生命体征参数和差异参数，基于包括表征生命体征的一个或多个生命体征参数的多个低血压分析参数的加权组合，确定对应于生活对象的未来低血压事件的概率的风险分数。签名数据，差分参数和组合参数，并且如果风险分数满足预定风险标准则调用感官警报。