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(54) Composite material endoprosthesis
Endoprosthese aus Verbundmaterial
Endoprothèse en matériau composite

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EP-A- 0 809 998
WO-A-93/19803
WO-A-95/30384
WO-A-97/13475

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Technical Field:

The present invention relates to endoprostheses, and in particular, to endoprostheses made of composite materials having radiographic contrast suitable for detection by X-ray fluoroscopy with minimal interference in rendering Quantitative Coronary Angiographic Analysis.

Background of the Invention:

One type of endoprosthesis device, commonly referred to as a stent, is placed or implanted within a blood vessel for treating stenoses, strictures, or aneurysms in the blood vessel. These devices are implanted within the vascular system to reinforce diseased, partially occluded, weakened or abnormally dilated sections of the blood vessel. Stents also have been successfully implanted in the urinary tract or the bile ducts to reinforce and prevent neoplastic growth in blood vessels. One common procedure for implanting the stent is to wrap the stent around a balloon catheter, to place the stent in the diseased portion of the vessel, for example, and then to inflate the balloon to secure the stent in place in the vessel.

Stents must be manufacturable and have suitable physical properties including suitable radiopacity, biocompatibility, and mechanical properties such as hoop strength, fatigue resistance, and corrosion resistance. Many stents today are composed of stainless steel or other metals which in their product thickness are not easily detectable using X-ray fluoroscopy. Stents have been constructed from tantalum wire, as disclosed in U.S. Patent No. 5,135,536. However, tantalum wire is very radiopaque and thus, produces a very bright X-ray fluoroscopy image, which obscures the X-ray image resulting from the surrounding tissue and prevents the use of Quantitative Coronary Angiographic techniques for lumen size determination.

It is currently difficult to alter the radiopacity of an endoprosthesis without changing its physical properties. Physical properties of the endoprosthesis are very important. Some stents have very limited compliance characteristics, making them not particularly well suited for use in curved vessel pathways. For example, using stents having a generally rigid cylindrical shape in curved vessel pathways typically requires the stents to have a very short length and to be strung out along the curved pathway. Also, such stents are often delivered separately, thereby increasing the invasiveness of the procedure.

Previous approaches in endoprosthesis construction have used devices with good hoop strength. When stents are provided in relatively large vessels or deployed within a vessel susceptible to external forces, such as within the leg, good hoop strength is important to resist forces which tend to collapse the endoprosthesis.

WO 95/30384 discloses such an endoprosthesis, comprising two materials in a composite, wherein the first material forms a highly radiopaque core and the second material acts as a surrounding case, exhibiting high yield strength, such that the whole endoprosthesis exhibits high overall yield strength of at least 1 GPa (150,000 psi).

WO 94/16646 discloses a process for manufacturing the endoprosthesis disclosed in WO 95/30384.

WO 93/19803 discloses a medical device having a metal outer member and an inner core with low elasticity, for enhancing the radiopacity of the device, the core being present in an amount of between 10 to 50% of the device by volume.

Other endoprostheses exhibit less hoop strength but are more compliant and are better suited to conform to the contour of the vessel, rather than being so non-conforming as to misshape the vessel after deployment. A typical disadvantage of more compliant stent devices is that they tend to deform upon or after deployment and present stenting surfaces that can lack desirable uniformity throughout the working surface area of the stent. A non-uniform working surface area of the stent is especially evident during expansion of the stent from its collapsed, insertion diameter to its expanded, implanted diameter. At times, this lack of uniformity upon expansion is exacerbated by folds or other nonuniformities in the balloon on which the stent is mounted for deployment.

EP 0 809 998 discloses an endoprosthesis including a body structure formed of a biocompatible material. The body structure includes a first material having an average atomic number greater than 24 and a second material that is different than the first material. The first material is present in an amount not greater than 9% by volume based on the combined volume of the first material and the second material. The body structure has a mass absorption coefficient effective to provide a ratio of an intensity of an incident X-ray to an intensity of a transmitted X-ray in a range of $10^{-2}$ to $10^{-4}$. More specifically, either the endoprosthesis itself or a stent made from this material has a tensile strength of 552 to 965 MPa (80,000-140,000 pounds per square inch ("psi")) with a minimum elongation of 10 percent.

Summary of the Invention:

The present invention is directed to a composite material endoprosthesis with predetermined radiopacity char-
According to the invention, there is provided an endoprosthesis as set forth in the accompanying claim 1. Further aspects of the invention are set out in the accompanying dependent claims 2 to 13.

One embodiment of the present application is directed to an endoprosthesis including a tubular body structure formed of a biocompatible material. An annular layer of the body structure forms an opening for receiving a member for expanding the endoprosthesis. The body structure comprises the first material having an average atomic number greater than 24 and the second material which is different from the first material. The first material is present in an amount in a range of from 30 to 40% by volume based on a combined volume of the first and second materials. The body structure has a mass absorption coefficient effective to provide a ratio of an intensity of an incident X-ray to an intensity of a transmitted X-ray in a range of 1e-2 to 1e-4. More specifically, the endoprosthesis has a yield strength not greater than 689 MPa (100,000 pounds per square inch) and, in particular, not greater than 552 MPa (80,000 pounds per square inch). The endoprosthesis preferably has a hoop strength of at least 41 kPa (6 pounds per square inch). The endoprosthesis preferably has at least one opening or window formed in a wall of a body structure to facilitate expansion or collapse of the body structure such as during deployment using a balloon catheter.

The tubular body structure is preferably comprised of at least two generally annular layers. One of the first and second materials comprises one of the layers and the other of the first and second materials comprises another one of the layers. In preferred form, the body structure comprises an outer annular layer, an inner annular layer and an intermediate annular layer disposed between the outer layer and the inner layer. The first material is preferably selected from the group consisting of gold, platinum, tantalum, iridium, tungsten, alloys thereof and any combination thereof. The second material may be selected from the group consisting of cobalt, carbon, manganese, silicon, phosphorus, sulfur, chromium, nickel, molybdenum, titanium, iron, alloys thereof and any combination thereof. The second material may be a cobalt alloy. One suitable second material alloy comprises cobalt, carbon, manganese, silicon, phosphorus, sulfur, chromium, nickel, molybdenum, titanium and iron. Another suitable second material alloy comprises cobalt, carbon, manganese, silicon, chromium, nickel, phosphorus, molybdenum, iron and sulfur.

Certain materials are not preferred for use in the endoprostheses of the present invention. For example, when present in excessive amounts, palladium, copper, zinc and lead are toxic in the human body and would require a protective coating to be usable. Magnetic or ferromagnetic materials are undesirable for use in the endoprostheses of the present invention when used in excessive amounts for certain applications. When a patient has a stent made of a magnetic or ferromagnetic material in the body, the use of Magnetic Resonance Imaging (“MRI”) could be a problem since the stent may cause an artifact of the MRI image, be displaced by the magnetic field or heat up in the magnetic field. This prevents stents made of magnetic and ferromagnetic materials from being used in the brain for which an MRI Spiral Computed Tomography (“CT”) procedure is commonly performed.

The endoprostheses of the present invention are suitable for any application in which tailored radiographic contrast and physical properties are desirable. The endoprostheses may be formed into different sizes and shapes, as well as with different physical properties, depending upon where they are used in the body. The endoprostheses may advantageously be used to form coronary stents, peripheral stents, stent grafts and the like. The endoprostheses of the invention may also be used to form suture clips, vena cava filters, heart valves, guidewires and tube stiffening systems such as Palmaz stents by Johnson & Johnson Interventional Systems.

Selecting the size of the tubular member is important for achieving the desired radiographic contrast depending upon the particular application.

The present invention avoids the problems of conventional endoprostheses materials having fluoroscopic signatures that are either too dim such as observed with stainless steel endoprostheses, or are too bright as in the case of endoprostheses comprising only tantalum. The endoprostheses of the present invention obtain good radiographic contrast without adversely altering their necessary physical properties. The radiographic contrast is obtained by selecting the mass absorption coefficient to provide a ratio of an intensity of an incident X-ray to an intensity of a transmitted X-ray in a range of 1e-2 to 1e-4. Thus, the endoprostheses of the present invention are bright enough to be seen during X-ray fluoroscopy but dim enough to allow the surrounding vessel or tissue to be seen through the endoprostheses and to perform Quantitative Coronary Angiography techniques.

The specific embodiments referred to as well as possible variations and the various features and advantages of the invention will become better understood from the accompanying drawings together with the detailed description that follows.
Brief Description of the Drawings:

[0022]

Figure 1 is a perspective cross-sectional view showing a disclosed embodiment of an endoprosthesis.
Figure 2 is a perspective cross-sectional view showing an embodiment of an endoprosthesis constructed in accordance with the present invention.
Figure 3 is an endoprosthetic tube formed from the endoprosthesis shown in Figure 2.
Figure 4 is a graph showing radiographic contrast as a function of wire diameter or section thickness.
Figure 5 is a graph showing linear absorption coefficient as a function of wire diameter or section thickness.
Figure 6 is a graph showing radiographic contrast as a function of section thickness.

Detailed Description of Preferred Embodiments:

[0023] Turning now to the drawings, Figure 1 shows one form of an endoprosthesis 10 having a body structure including a biocompatible material. Each endoprosthesis 10 of the present invention has a composition that preferably includes two or more materials, a radiopaque first material and a second material that is different than the first material and imparts certain properties to the body structure.

[0024] In a disclosed embodiment, the body structure is in the form of an elongated wire member including a central cylindrical core 12 and an outer tubular sheath 14 disposed around the core 12. The core 12 and the sheath 14 both have a generally uniform transverse cross-sectional area along their lengths. The sheath 14 has an inner diameter d1 and an outer diameter d2. The inner diameter d1 of the sheath 14 is of a size sufficient to accommodate the core 12, which has a diameter d3. The body structure may have additional, generally annular layers disposed radially outside the sheath 14 or between the sheath 14 and the core 12. Alternatively, the body member may be formed from a single composite material as a solid cylindrical wire without a tubular sheath or, in accordance with one embodiment of the present invention, as a tubular member comprised of both the first and second materials in a single layer.

[0025] Figure 2 shows another form of the endoprosthesis 10 of the present invention, including a laminate structure 16 having first and second layers 18, 20. The first layer 18 has a thickness t1 and the second layer 20 has a thickness t2. Additional layers may also be used either between or outside the first and second layers 18, 20.

[0026] A tubular body structure or hypotube 22 shown in Figure 3 may be formed from the laminate structure 16 of Figure 2. In the hypotube configuration shown in Figure 3, the layer 18 forms a generally annular inner tubular layer and the layer 20 forms a generally annular outer tubular layer. A generally annular intermediate tubular layer may be disposed radially between the inner tubular layer 18 and the outer tubular layer 20.

[0027] Openings or windows 24 may be formed in the walls of the hypotube 22. The windows are preferably cut from the composite tube 22 to allow the endoprosthesis to be expandable to different diameters and to be collapsed such as when wrapped around a balloon catheter. The windows allow beam sections to develop between windows which will have elastic and plastic zones, consistent with the stent configuration by Palmaz developed by Johnson and Johnson Interventional Systems.

[0028] It is important to be able to detect the position of the endoprosthesis using X-ray fluoroscopy or Magnetic Resonance Imaging during deployment and post deployment inspections of the endoprosthesis. The endoprosthesis is detected when the material in the endoprosthesis body structure absorbs a sufficient intensity of a transmitted X-ray beam to be detected as a different intensity than the intensity of an initial X-ray beam. This relationship is empirically presented by the following equation:

\[
I_x = I_0 e^{-\frac{\mu}{\rho} \rho x}
\]

where:

\( I_x \) is the intensity of the transmitted X-ray beam after passing through a thickness \( x \);

\( I_0 \) is the intensity of the incident X-ray beam;

\( \mu/\rho \) is the mass absorption coefficient of the endoprosthesis;

\( \mu \) is the linear absorption coefficient;
\[ \rho \text{ is the density of the endoprosthesis; and} \]

\[ \times \text{ is the thickness or diameter of the endoprosthesis.} \]

Equation 1 may be used for determining the radiopacity of each element and each alloy in the core, the sheath and the layers of the composite endoprosthesis structure. The mass absorption coefficient of the composite endoprosthesis used in Equation 1 is determined by summing the weight fractions of the mass absorption coefficients of each elemental component of the complete endoprosthesis. The mass absorption coefficient of each elemental component is related to the X-ray wavelength of the incident X-ray and the atomic number of each elemental component as follows:

\[ \mu/\rho = k \lambda^3 Z^3 \]  

where:

\[ \mu/\rho \] is the mass absorption coefficient of each elemental component;

\[ k \] is a constant;

\[ \lambda \] is the X-ray wavelength; and

\[ Z \] is the atomic number of each elemental component.

By summing the elemental weight fraction multiplied by the elemental atomic number and the X-ray fluoroscopy X-ray wavelength, for each element in the composite endoprosthesis, the mass absorption coefficient of the entire composite endoprosthesis can be determined.

Radiographic contrast is the difference in X-ray intensity transmitted through one interaction area of a material as compared to that transmitted through another interaction area of the material. Radiographic contrast is the relationship between the transmitted X-ray beam through the endoprosthesis and the transmitted X-ray beam through the surrounding tissue. Radiographic contrast for an endoprosthesis is defined as follows:

\[ I_s/I_l \]  

where:

\[ I_s \] is the intensity of the X-ray beam transmitted through the endoprosthesis;

and

\[ I_l \] is the intensity of the X-ray beam through tissue.

The X-ray intensity of the composite endoprosthesis and the surrounding tissue used in Equation 3 can be calculated using Equation 1. The radiographic contrast between tissue and bone is approximately equal to one.

The present invention permits the radiographic contrast of the endoprosthesis to be predetermined by controlling the mass absorption coefficient. The mass absorption coefficient is controlled by selecting the composite material used and the thickness or diameter of the entire endoprosthesis, e.g., d2 or t1+t2. By using preferably two or more materials, each having different physical properties, the radiographic contrast may be adjusted as desired without altering the physical properties of the entire endoprosthesis including fatigue resistance, corrosion resistance, tensile strength, toughness and biocompatibility. This is because by employing a structure having a tubular member and core, for example, the amount of the radiopaque material in the core can be adjusted while maintaining the amount of the structural material in the tubular member needed for the requisite physical properties.

The mass absorption coefficients must be carefully selected to produce a radiographic contrast within a preferred range. It is important to design the composite structure so that the fluoroscopy signature of the endoprosthesis is adequately detectable or bright, and yet does not develop an X-ray artifact which interferes with X-ray signatures of the vessel wall. In other words, the X-ray fluoroscopy images of the radiopaque materials must not be excessively bright. Experimental studies on the radiopacity of endoprostheses of the present invention using adult mongrel canine
and pygmy swine porcine have indicated that the ideal fluoroscopic signature correlates to a radiographic contrast in a range of $10^{-2}$ to $10^{-4}$. This contrast range provides sufficient intensity to detect the endoprosthesis without, for example, altering quantitative angiographic measurement.

[0035] Figure 4 shows the radiographic contrast versus outer diameter $d_2$ in the Figure 1 configuration or total layer thickness $(t_1 + t_2)$ in the Figure 3 configuration for different material systems. The rectangular region defined by the solid lines along the x-axis between 0.1016 to 0.2540 mm (0.0040 and 0.0100 inches) is a region of desired radiographic contrast. This region of desired radiographic contrast corresponds to ideal fluoroscopic conditions for stents composed of laminate layers in a tube configuration and for large diameter wire used and for large diameter vessels such as an aortic or vena cava lumen.

[0036] The rectangular region defined by the dotted lines along the x-axis in Figure 4 between 0.1270 to 0.1905 mm (0.0050 and 0.0075 inches) is a region of preferred radiographic contrast. This preferred region corresponds to ideal fluoroscopic conditions for coronary and peripheral stents composed of wire. The following description herein, unless otherwise indicated, refers to the disclosed wire embodiment shown in Figure 1, although it is equally applicable to the laminate and hypotube embodiments of the invention as shown in Figures 2 and 3.

[0037] Both the desirable and preferred radiographic contrast regions fall within the predetermined requisite radiographic contrast range along the y-axis of $10^{-2}$ to $10^{-4}$. The radiographic contrast range of the present invention is particularly important in the case of stents which, when expanded, enter the vessel wall. After the resultant restenosis it is important to be able to see the vessel wall through the stent. For this reason, the endoprosthesis needs to be bright enough during X-ray fluoroscopy to be seen, but dim enough to be seen through. Being able to see through the endoprosthesis means that the X-ray signature from the endoprosthesis does not create an X-ray artifact which masks the surrounding vessel and tissue. This allows an accurate measurement of the vessel lumen size after implantation. At radioscopic contrast greater than $10^{-2}$ the endoprosthesis is too dim for the surrounding tissue or vessel wall to be seen. X-ray images showing the radiographic contrast of $10^{-2}$ were observed in a canine study of the endoprostheses of the present invention at the Institut de Cardiologie de Montreal and were presented on a real time video and on X-ray film. At radiographic contrast less than $10^{-4}$ the endoprosthesis is too bright for the surrounding tissue or vessel wall to be seen. Thus, the endoprostheses of the present invention are constructed to have a range of radiographic contrast between $10^{-2}$ to $10^{-4}$, which strikes a balance between seeing the endoprosthesis and seeing the surrounding vessel wall or tissue during X-ray fluoroscopy.

[0038] The sheath or outer tube 14 preferably has an outer diameter $d_2$ ranging from 0.0508 to 0.3810 mm (0.0020 to 0.0150 inches). More preferably, the sheath 14 has an outer diameter $d_2$ ranging from 0.1016 to 0.2540 mm (0.0040 to 0.0100 inches), as shown by the combined range of the desirable and preferred radiographic contrast regions in Figure 4. Even more preferably, the sheath 14 has an outer diameter $d_2$ ranging from 0.1270 to 0.1905 mm (0.0050 to 0.0075 inches), as shown by the preferred dotted region in Figure 4. A core diameter $d_3$ ranging from 0.0254 to 0.0635 mm (0.0010 to 0.0025 inches) achieves optimal radiographic contrast for all applications. For the hypotube shown in Figure 3, each of the outer generally annular layer, the inner generally annular layer and the intermediate generally annular layer has a wall thickness ranging from 0.0127 to 0.0762 mm (0.0005 to 0.0030 inches).

[0039] The core and sheath diameters $d_1$, $d_2$ and $d_3$ of the composite endoprosthesis 10 vary depending upon the intended use of the endoprosthesis 10. When the endoprostheses 10 are used to form coronary stents, the outer diameter $d_2$ ranges from 0.1270 to 0.1524 mm (0.0050 to 0.0060 inches). For use in saphenous vein grafts the outer diameter $d_2$ ranges from 0.1397 to 0.1651 mm (0.0055 to 0.0065 inches). For peripheral stents, such as for use in iliac and biliary lumens, for use in the brain, and for abdominal aortic aneurysms, the outer diameter $d_2$ ranges from 0.1905 to 0.2540 mm (0.0075 to 0.0100 inches). The laminate structure 16 has an overall size (e.g., $t_1$ and $t_2$) that also varies depending upon the application of the endoprosthesis and may have the same sizes as the outer wire diameter $d_2$ and the core diameter $d_3$ discussed above.

[0040] Figure 5 shows linear absorption coefficient as a function of wire diameter or section thickness. The shaded region shows the desired linear absorption coefficient across outer wire diameters $d_2$ ranging from 0.1016 to 0.1905 mm (0.0040 to 0.0075 inches). The following Table I shows average atomic numbers, and hence elements that may be used, to form a composite endoprosthesis with radiographic contrast ranging from $10^{-2}$ to $10^{-4}$.

<table>
<thead>
<tr>
<th>Wire Diameter or Section Thickness mm (inch)</th>
<th>Average atomic number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.1016 (0.004)</td>
<td>63-71</td>
</tr>
<tr>
<td>0.1270 (0.0050)</td>
<td>28-70</td>
</tr>
<tr>
<td>0.1905 (0.0075)</td>
<td>26-64</td>
</tr>
</tbody>
</table>
A unique and important characteristic of the present invention is its ability to use multiple materials that each exhibit superior performance for some of the required physical properties. In the disclosed embodiment, the core is preferably selected to provide the composite endoprosthesis with good radiopacity while the sheath is preferably selected to provide the composite endoprosthesis with good physical properties. An endoprosthesis may thus be designed to have suitable radiographic contrast without adversely affecting the physical properties of the endoprosthesis.

The first material includes one or more materials with an atomic number (elemental) or an average atomic number ranging from 24-71, as shown in Table I. For example, the first material is preferably selected from the group consisting of gold, platinum, tantalum, iridium, tungsten, alloys thereof and any combination thereof. A preferred first material, tantalum, may be obtained from the Cabot Corporation.

The second material has chemical and physical properties that are compatible with the first material. The second material may be a nickel cobalt alloy such as an alloy including cobalt, carbon, manganese, silicon, phosphorus, sulfur, chromium, nickel, molybdenum, iron and titanium. Other materials may be used for the second material, such as an alloy including cobalt, carbon, manganese, silicon, chromium, nickel, phosphorus, molybdenum, sulfur and iron.

One composition for the second material is known as 304V supplied by Carpenter Technology Corporation and has the following nominal composition (% by weight): carbon: 0.03 maximum; manganese: 2.00 maximum; silicon: 1.00 maximum; chromium: 18.0-20.0; nickel: 8.0-12.0; phosphorus: 0.045 maximum; sulfur: 0.03 maximum; with the balance being iron.

Another composition for the second material is known as 316 LVM supplied by Carpenter Technology Corporation and includes the following nominal composition (% by weight): carbon: 0.03 maximum; manganese: 2.00 maximum; silicon: 1.00 maximum; chromium: 16.0-18.0; nickel: 10.0-14.0; phosphorus: 0.045 maximum; sulfur: 0.03 maximum; molybdenum: 2.0-3.0; with the balance being iron.

A preferred composition for the second material is known as MP35N (supplied by Carpenter Technology Corporation and the Latrobe Steel Company) and has the following nominal composition (% by weight): carbon: 0.025 maximum; manganese: 0.15 maximum; silicon: 0.15 maximum; phosphorus: 0.015 maximum; sulfur: 0.010 maximum; chromium: 19.0-21.0 maximum; nickel: 33.0-37.0; molybdenum: 9.0-10.5; iron: 1.0 maximum; titanium: 1.0 maximum; with the balance being cobalt.

In a disclosed embodiment of the composite body structure the first material is present in an amount of from 2 to 9% by volume based on the combined volume of the first and second materials. One preferred composite material includes 91 volume % MP35N and 9 volume % Ta. Other preferred composite materials include either 93 volume % MP35N and 7 volume % Ta or 96 volume % MP35N and 4 volume % Ta. These materials exhibit radiographic contrasts that fall completely within the preferred dotted region across wire diameters in the range of from 0.1270 to 0.1905 mm (0.0050 to 0.0075 inches).

Other endoprosthesis materials are those that comprise only tantalum or platinum and a material including 67 volume % MP35N and 33 volume % Ta (MP35N-33Ta). These materials have X-ray fluoroscopic signatures that may be too bright for the surrounding tissue or vessel wall to be seen in the case of wall or section thicknesses greater than 0.1016 mm (0.004 inches).

Although the lower limit of the desirable region of wire diameter is shown as 0.1016 mm (0.0040 inches) in Figure 4, a wire diameter of 0.1270 mm (0.0050 inches) or more is preferable. At wire diameters under 0.1270 mm (0.0050 inches), the disclosed endoprosthesis may not possess desirable hoop strength. A minimum hoop strength of 13.3 kPa (100 mm of Hg) must be maintained for an endoprosthesis. A disclosed endoprosthesis having the configuration shown in Figure 1 should have a 0.1016 mm (0.0040 inch) diameter or greater to satisfy this hoop strength. An endoprosthesis of the invention having the configuration shown in Figure 3 may require a thickness of 0.0762 to 0.0508 mm (0.0030 or 0.0020 inches) to satisfy this hoop strength. Therefore, although the MP35N-33Ta composition and other materials with a high radiopaque material content may have acceptable radiographic contrast under 0.1270 mm (0.0050 inches) in wire diameter as shown in Figure 4, it may not be feasible to make wire shaped endoprostheses from such materials, due to their undesirably low hoop strengths.

Although an endoprosthesis composed of a single material system such as one of palladium, MP35N or 304V falls within the region of acceptable radiographic contrast as shown in Figure 4, these materials have certain drawbacks. Palladium is toxic in the human body and would require a protective coating to be usable. An endoprosthesis comprising either MP35N or 304V alone only has acceptable contrast for wire diameters in excess of about 0.1524 mm (0.0060 inches), which prevents these materials from being used for coronary stents.

Iron-based materials may present problems in some applications when present in excessive amounts in the
endoprostheses having a tubular body structure such as that shown in Figure 3. The endoprosthesis includes amounts of the first material in the range of about 30 to about 60% by volume based on the combined volume of the first and second materials. This endoprosthesis is especially tailored for deployment such as using a balloon catheter and has a yield strength less than 689 MPa (100,000 psi) and, in particular, less than 552 MPa (80,000 psi), considering only the strength of the second material.

Any of the first and second materials described herein may be used in this embodiment. For example, either MP35N or 316LVM may be used as the second material and tantalum may be used as the first material. A hypotube may be constructed with one, two, three or more layers. A mixture of the first and second materials may be used in only one layer in the hypotube.

Alternatively, in the case of a hypotube using MP35N and tantalum, MP35N may be disposed in an outer generally annular layer and tantalum may be used in an inner generally annular layer.

In another aspect, a multilayered hypotube may use 316LVM for one or both of inner and outer generally annular layers and an intermediate generally annular layer of tantalum is disposed between the inner and outer layers. Forming both the inner and outer layers of 316LVM imparts the hypotube with additional strength, since 316LVM is not as strong as MP35N.

Figure 6 shows overall hypotube section (annular layer) thickness (e.g., t1+t2 or t1+t2+t3) for MP35N/30 volume % tantalum, MP35N/33 volume % tantalum and MP35N/40 volume % tantalum as well as 316LVM/30 volume % tantalum and 316LVM/40 volume % tantalum. The use of these materials expands the desirable overall section thickness size to a minimum of about 0.0254 mm (0.001 inches) as shown by the box designating desirable radiographic contrast in Figure 6. As section thicknesses may be smaller in the hypotube compared to wire geometry (see the boxes of desirable radiographic contrast in Figures 4 and 6), a higher loading of the first material may be used in the hypotube construction.

The endoprostheses of the present invention and of the disclosed embodiments are made by obtaining composite filaments manufactured by a drawn filled tubing ("DFT") process such as that performed by Ft. Wayne Metals Research Products Corporation of Ft. Wayne, Indiana. A tube made of the second material has an inner diameter that permits a core wire made of the first material to be inserted into it and to be substantially radially centered in the tube. The inner and outer diameters of the tube and the diameter of the disclosed core wire vary depending on the materials used. The inside and outside diameter of the sheath material and the outside diameter of the core material at the start of the manufacturing process vary based upon the particular starting material and the desired percent by volume of the core. The tube and core wire may be at least twenty feet in length. The core wire is inserted into a central opening of the tube to form a disclosed composite filament.

The filament then undergoes a plurality of alternating cold working and annealing steps. For example, the filament may be drawn through three dies. In each die, the filament is cold worked in radial compression, which causes it to flow, thereby reducing its diameter and increasing its length. The tube may be radially reduced and lengthened more rapidly than the wire at first, due to a gap initially present between the wire and the tube. After the gap is closed, the core wire and tube are radially reduced and lengthened at substantially the same rate.

Passing through each of the dies induces strain hardening and other stresses into the filament, which are removed by one or more annealing steps. In each of the annealing steps the filaments are heated at a temperature ranging from about 1038 to 1260 °C (1900 to about 2300 °F). Each annealing step removes nearly all of the induced stresses from the filament. Each annealing step may last between, for example, 1 to 30 seconds at the annealing temperature, depending on the size of the filament. The number of cold working and annealing steps depends on the initial filament size, the materials used and the desired radial reduction. In the wire drawing process, the composite material is drawn down in successive dies at a 10% reduction in area per die. Between each annealing cycle there is a 30 to 50% reduction in area.

The resulting endoprosthesis may then be formed into a stent by a process known to those skilled in the art, such as that described in U.S. Patent Application Serial No. 08/123,440 to Williams, entitled "Endoprosthesis Having Laser Welded Junctions, Method and Procedure," filed June 16, 1995.

The laminate hypotube of the invention may be manufactured by one of two processes. In the first process the hypotube may be produced by hot rolling a series of layers of material into a laminate sheet. Each layer includes one or more second structural material such as MP35N and one or more first radiopaque material such as tantalum. The hot rolling process may be optimized to ensure mechanical bonding between the multiple layers and that the composite material has a tensile strength ranging from 483 to 827 MPa (70,000 to 120,000 psi) with 5 to 30 percent elongation. Elongation is defined as the percent increase in the length of a component prior to failure when a tensile load is applied to the component. The laminate sheets may then be rolled up around a mandrel and seam welded to form a tube. The seam welded tube can then be drawn to final size.
The second process for making the hypotube is to place multiple layers of tubes within each other around a core mandrel. The composite structure may then be drawn and heat treated using conventional wire drawing practices until the finished tube diameter meets the physical properties and dimensions required. A sacrificial ductile core mandrel is placed within the hypotube prior to the wire drawing process. The composite system is then drawn to finish dimensions and the core mandrel is removed. Removal of the mandrel is achieved by reducing the cross section of the mandrel. By solely pulling the mandrel, the diameter of the mandrel can be reduced sufficiently to be easily removed.

Once a composite hypotube is obtained, the structure may be loaded onto a lathe type tool and windows may be cut from this tube using, for example, a laser, a cutting tool, a water saw, or an electron discharge machining ("EDM") process. In the EDM process a wire is used as a cutting tool and placed in contact with the part. An electrical pulse is transferred through the wire and an electrical discharge occurs, burning a fine cut in the part. The EDM process accurately cuts the part without inducing stresses in it. Once the windows are cut from the tube, the tube may then be deburred by a procedure such as shot peening, abrasive tumbling, honing, electropolishing and electroetching.

The windows are important to the function of the endoprosthesis. When the endoprosthesis is in the form of a stent, the stent is required to be crimped down onto a balloon catheter at a size smaller than the original hypotube and deployed to a size at less than twice the diameter of the hypotube. To achieve this task, regions need to exist within the endoprosthesis where plastic deformation can result in thin sections allowing the expansion and contraction of the endoprosthesis to occur at a low pressure of approximately 2 atmospheres.

The disclosed core and sheath materials are preferably selected to have physical properties, such as coefficients of thermal expansion, annealing temperature ranges, and elastic moduli, which are compatible with each other. Matching the Young's Moduli of the core and sheath materials is well within the ability of those skilled in the art in view of the instant disclosure. The component with the largest cross-sectional area must have a Young's Modulus equal or greater to the Young's Modulus of the other component.

If this does not occur, the multiple layers of the endoprosthesis will delaminate during the manufacturing process or during in vivo use. The endoprosthesis material must also be biocompatible and non-toxic so that it will not result in an inflammatory reaction from the body.

Important mechanical properties for the endoprostheses of the present invention are toughness, tensile strength and hoop strength. The composite structure or alloy must have sufficient toughness, i.e., enough resistance to failure to prevent the initiation and propagation of cracks during the stress history of the endoprosthesis. The stress history includes the application of a load during the manufacturing process and during deployment, and cyclic loading in the human body. The endoprosthesis may have a toughness ranging from 20 to 120 joules.

It is preferred that the endoprosthesis, or a stent, for example, that is made from the endoprosthesis, be plastically deployed by a balloon. Such an endoprosthesis or a stent made therefrom has an ultimate tensile strength in the range of 552 to 965 MPa (80,000-140,000 psi) and 10% minimum elongation and, more preferably, an ultimate tensile strength of 552 to 758 MPa (80,000 to 110,000 psi). Even more preferably, the endoprosthesis has a yield strength less than 689 MPa (100,000 psi), and in particular, less than 552 MPa (80,000 psi). The endoprosthesis may have a yield strength of about 414 MPa (60,000 psi) when MP35N is used as the second material. A minimum hoop strength of 100 mm of Hg is required to keep a vessel open.

The surface of the sheath or outer laminates is preferably free of imperfections with a surface finish of no more than 762 nm (30 μm) roughness. Such a surface finish minimizes the development of crack nucleation sites on the surface of the endoprosthesis. A defect-free surface minimizes the incidence of fatigue failure as well as the possibility of thrombus generation and tissue inflammation.

The composite material must also be corrosion resistant as specified in the document, Guidance for the Submission of Research and Marketing Applications For Interventional Cardiology Devices: PTCA Catheters Atherectomy Catheters Lasers Intervascular Stents, the Interventional Cardiology Branch Division of Cardiovascular, Respiratory and Neurological devices Office of Device Evaluation, May 1994. In a ten year product life in saline, the composite structure is preferably sufficiently noble to prevent surface corrosion from degrading the endoprosthesis, and must prevent crevice corrosion or galvanic corrosion from degrading the endoprosthesis between the layers.

1. An endoprosthesis (10) including a tubular body structure (22) formed of a biocompatible material, an annular layer (18, 20) of said body structure forming an opening for receiving a member for expanding the endoprosthesis, wherein said body structure comprises a first material having an average atomic number greater than 24 and a second material that is different than said first material, wherein said body structure has a mass absorption coefficient effective to provide a ratio of an intensity of an incident X-ray to an intensity of a transmitted X-ray in a range of le-2 to le-4, characterised in that said first material is present in an amount in a range of from 30 to 40% by volume based on a combined volume of said first material and said second material.
2. The endoprosthesis of claim 1 wherein the endoprosthesis (10) has a yield strength not greater than 689 MPa (100,000 pounds per square inch).

3. The endoprosthesis of claim 1 or claim 2 wherein the endoprosthesis (10) has a hoop strength of at least 41 kPa (6 pounds per square inch).

4. The endoprosthesis of claim 1, 2 or 3 wherein said body structure (22) is comprised of at least two generally annular layers (18, 20).

5. The endoprosthesis of claim 4 wherein one of said first material and said second material comprises one of said layers (18) and the other of said first material and said second material comprises another one of said layers (20).

6. The endoprosthesis of any preceding claim wherein said body structure (22) comprises an outer generally annular layer (20), an inner generally annular layer (18) and an intermediate generally annular layer disposed between said outer layer and said inner layer, wherein one of said first and second materials comprises the intermediate layer and the other of said first and second materials comprises at least one of the outer layer (20) and the inner layer (18).

7. The endoprosthesis of claim 6 wherein said first material comprises said intermediate layer and said second material comprises at least one of said inner layer (18) and said outer layer (20).

8. The endoprosthesis of any one of claims 4 to 7 wherein each of said layers (18, 20) has a wall thickness ranging from 0.0127 to 0.0762 mm (0.0005 to about 0.0030 inches).

9. The endoprosthesis of any preceding claim wherein said first material is selected from the group consisting of gold, platinum, tantalum, iridium, tungsten, alloys thereof, and any combination thereof.

10. The endoprosthesis of any preceding claim wherein said second material is nonmagnetic.

11. The endoprosthesis of any preceding claim, wherein said second material is selected from the group consisting of carbon, manganese, silicon, chromium, nickel, phosphorus, sulfur, molybdenum, titanium, cobalt, iron, alloys thereof and combination thereof.

12. The endoprosthesis of any preceding claim wherein said second material comprises a cobalt alloy.

13. The endoprosthesis of any preceding claim comprising at least one opening (24) formed in a wall of said body structure (22) to facilitate expansion and collapse of said body structure.

Patentansprüche

1. Endoprothese (10), welche einen Rohrkörper (22) aus einem biokompatiblen Material und eine Ringlage (18, 20) um den Rohrkörper herum aufweist, welche eine Öffnung zur Aufnahme eines Elementes zum Dehnen der Endoprothese hat, wobei der Körper aus einem ersten Material mit einer Durchschnittsordnungszahl größer als 24 und einem zweiten Material, das sich von dem ersten Material unterscheidet, besteht und wobei der Körper einen solchen Massenabsorptionskoeffizienten hat, daß das Intensitätsverhältnis eines einfallenden Röntgenstrahles zu einem transmittierten Röntgenstrahl im Bereich 1e-2 bis 1e-4 liegt, dadurch gekennzeichnet, daß das erste Material in einem Anteil im Bereich von 30 bis 40 Volumenprozent bezogen auf das kombinierte Volumen des ersten und des zweiten Materials vorliegt.

2. Endoprothese nach Anspruch 1, welche eine Fließgrenze von nicht mehr als 689 MPa (100.000 Pfund pro Quadratzoll) aufweist.

3. Endoprothese nach Anspruch 1 oder 2, welche eine Tangentialspannungsfestigkeit von mindestens 41 kPa (6 Pfund pro Quadratzoll) aufweist.

4. Endoprothese nach Anspruch 1, 2 oder 3, bei welcher der Körper (22) aus mindestens zwei Ringlagen (18, 20) besteht.
5. Endoprothese nach Anspruch 4, bei welcher eine der Lagen (18) aus einem der beiden Materialien und die andere Lage (20) aus dem anderen der beiden Materialien besteht.

6. Endoprothese nach einem der bisherigen Ansprüche, bei welcher der Körper (22) aus einer äußeren Ringlage (20), einer inneren Ringlage (18) sowie einer Zwischen-Ringlage, welche zwischen der äußeren und der inneren Ringlage angeordnet ist, besteht, wobei die Zwischen-Ringlage aus einem der beiden Materialien und mindestens eine der beiden anderen Ringlagen (20, 18) aus dem anderen der beiden Materialien besteht.


8. Endoprothese nach einem der Ansprüche 4 bis 7, bei welcher die Lagen (18, 20) eine Wanddicke von 0,0127 mm bis 0,0762 mm (0.0005 Zoll bis etwa 0,0030 Zoll) haben.


10. Endoprothese nach einem der bisherigen Ansprüche, bei welcher das zweite Material unmagnetisch ist.


13. Endoprothese nach einem der bisherigen Ansprüche, welche mindestens eine in einer Wand des Körpers (22) geformte Öffnung (24) aufweist, um das Dehnen und das Kollabieren des Körpers zu erleichtern.

Revendications

1. Endoprothèse (10) comprenant une structure de type corps tubulaire (22) faite d'un matériau biocompatible, une couche annulaire (18, 20) de la structure de type corps formant une ouverture servant à recevoir un élément permettant de déployer l'endoprothèse, laquelle structure de type corps comprend un premier matériau ayant un poids atomique moyen supérieur à 24 et un second matériau différent dudit premier matériau, et laquelle structure de type corps possède un coefficient d'absorption massique efficace pour fournir un rapport entre l'intensité d'un rayon X incident et l'intensité d'un rayon X transmis se situant dans une plage de \(10^{-2}\) à \(10^{-4}\), caractérisée en ce que ludit premier matériau est présent dans une quantité se trouvant dans une plage de 30 à 40 % en volume basé sur volume combiné dudit premier matériau et dudit second matériau.

2. Endoprothèse selon la revendication 1, laquelle endoprothèse (10) possède une limite élastique ne dépassant pas 689 MPa (100000 livres par pouce carré).

3. Endoprothèse selon la revendication 1 ou la revendication 2, laquelle endoprothèse (10) possède une résistance circonférentielle d'au moins 41 kPa (6 livres par pouce carré).

4. Endoprothèse selon la revendication 1, 2 ou 3, dans laquelle ladite structure de type corps (22) comprend au moins deux couches essentiellement annulaires (18, 20).

5. Endoprothèse, selon la revendication 4, dans laquelle l'un desdits premier et second matériaux comprend une desdites couches (18), tandis que l'autre desdits premier et second matériaux comprend une autre desdites couches (20).

6. Endoprothèse selon l'une quelconque des revendications précédentes, dans laquelle ladite structure de type corps (22) comprend une couche externe essentiellement annulaire (20), une couche interne essentiellement annulaire (18) et une couche intermédiaire essentiellement annulaire disposée entre ladite couche externe et ladite couche.
interne, l’un desdits premier et second matériaux constituant la couche intermédiaire et l’autre desdits premier et second matériaux constituant l’une au moins des couches externe (20) et interne (18).

7. Endoprothèse selon la revendication 6, dans laquelle ledit premier matériau constitue ladite couche intermédiaire et ledit second matériau constitue au moins l’une desdites couches interne (18) et externe (20).

8. Endoprothèse selon l’une quelconque des revendications 4 à 7, dans laquelle chacune desdites couches (18, 20) possède une épaisseur de paroi allant de 0,0127 à 0,0762 mm (0,0005 à environ 0,0030 pouce).


10. Endoprothèse selon l’une quelconque des revendications précédentes, dans laquelle ledit second matériau est non magnétique.


12. Endoprothèse selon l’une quelconque des revendications précédentes, dans laquelle ledit second matériau comprend un alliage de cobalt.

13. Endoprothèse selon l’une quelconque des revendications précédentes, comprenant au moins une ouverture (24) formée dans une paroi de ladite structure de type corps (22) afin de faciliter le déploiement et le repli de ladite structure de type corps.