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Central Venous Access System

John Gurley

University of Kentucky, j.gurley@uky.edu

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USO 10004879B2

(12) **United States Patent**
Gurley

(10) **Patent No.:** **US 10,004,879 B2**
(45) **Date of Patent:** **Jun. 26, 2018**

(54) CENTRAL VENOUS ACCESS SYSTEM

(71) Applicant: University of Kentucky Research Foundation, Lexington, KY (US)

(72) Inventor: John Gurley, Lexington, KY (US)

(73) Assignee: **University of Kentucky Research Foundation, Lexington, KY (US)**

(* Notice: Subject to any disclaimer, the term of this patent is extended or adjusted under 35 U.S.C. 154(b) by 255 days.

(21) Appl. No.: **15/131,257**

(22) Filed: **Apr. 18, 2016** patent is extended or adjusted under 35 U.S.C. 154(b) by 255 days.

(65) **Prior Publication Data**

US 2016/0263352 A1 Sep. 15, 2016

Related U.S. Application Data

(62) Division of application No. 12/958,702, filed on Dec. 2, 2010, now Pat. No. 9,314,595.

(60) Provisional application No. 61/363,436, filed on Jul. 12, 2010, provisional application No. 61/266,298, filed on Dec. 3, 2009.

(51) **Int. Cl.**

A61M 25/00 (2006.01)

A61M 25/06 (2006.01)

A61M 25/101 (2006.01)

A61B 6/12 (2006.01)

A61B 17/34 (2006.01)

A61M 29/00 (2006.01)

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

CPC *A61M 25/065* (2013.01); *A61B 6/12* (2013.01); *A61M 25/01* (2013.01); *A61M 25/0194* (2013.01); *A61B 17/3415* (2013.01); *A61B 17/3478* (2013.01); *A61M 29/00* (2013.01)

(58) **Field of Classification Search**

None

See application file for complete search history.

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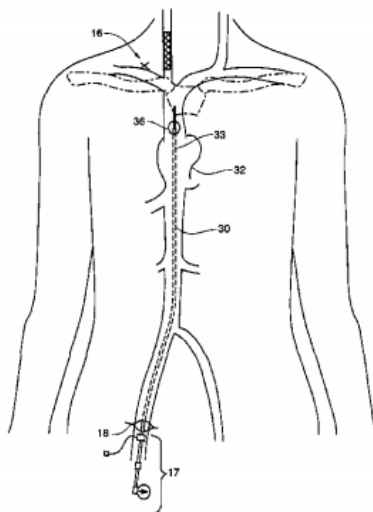
Primary Examiner - Aarti B Berdichevsky

(74) *Attorney, Agent, or Firm* - Norton Rose Fulbright US LLP

(57) **ABSTRACT**

A catheter system and method of use for re-establishing venous access near an occluded vessel.

13 Claims, 16 Drawing Sheets



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Fig. 1

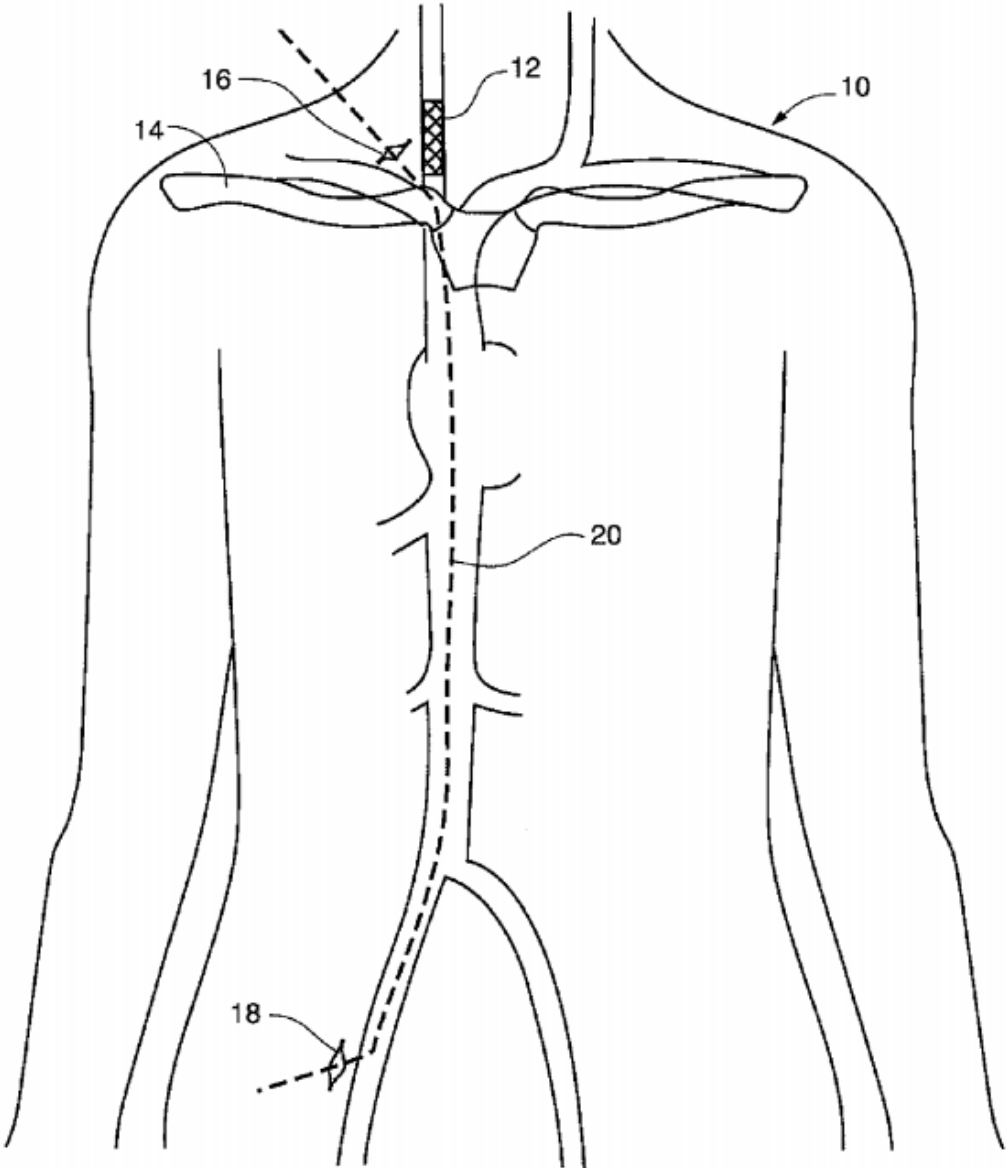


Fig. 2A

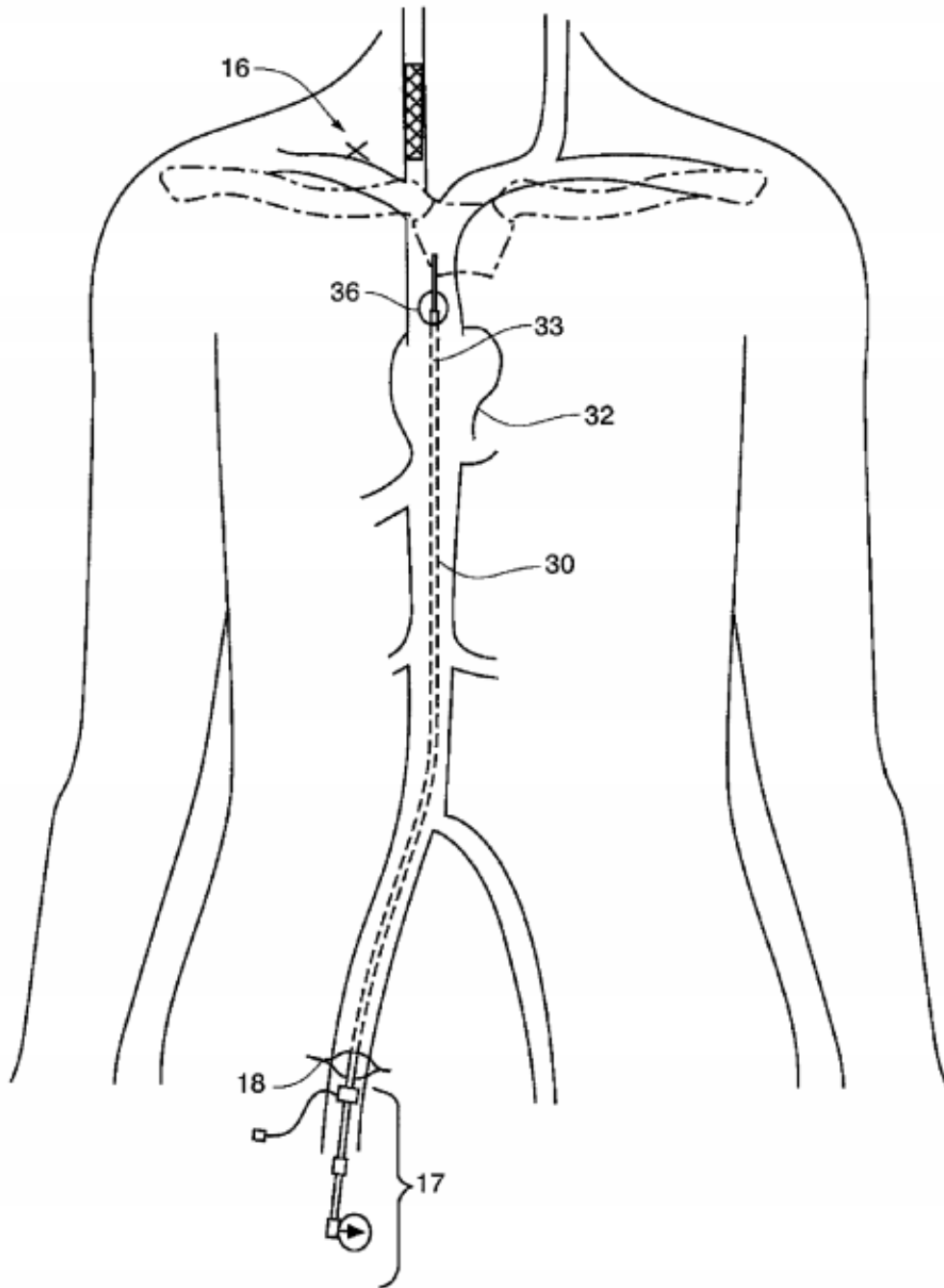
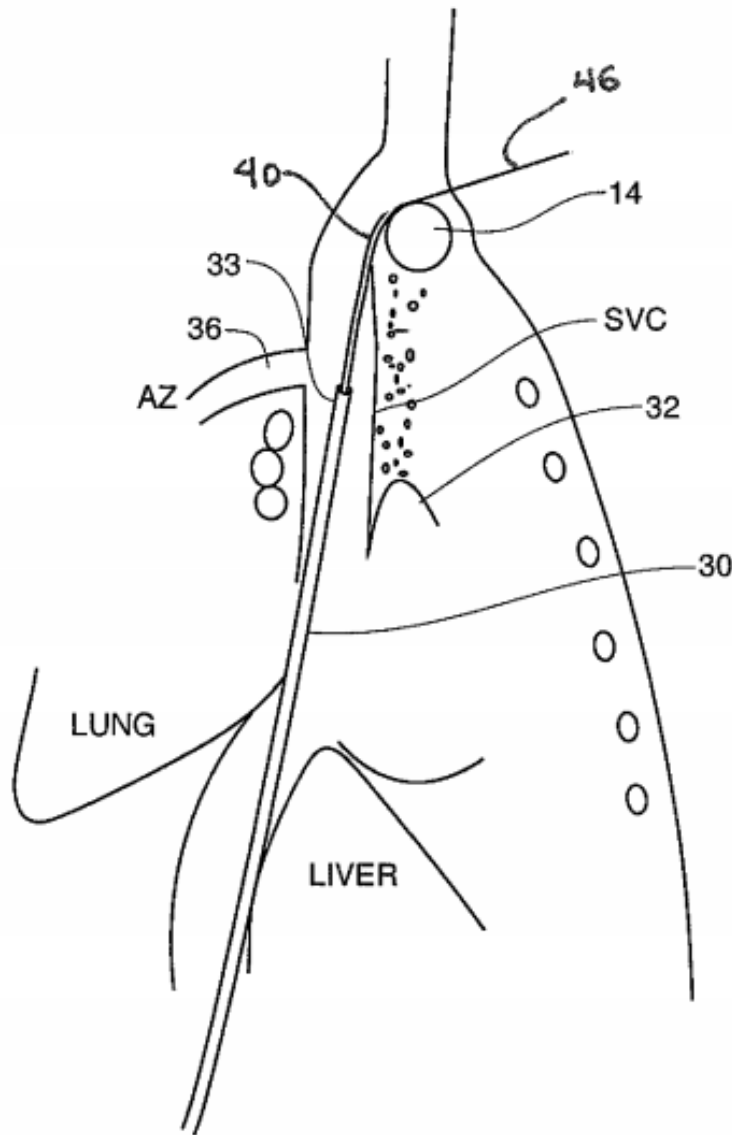


Fig. 2B



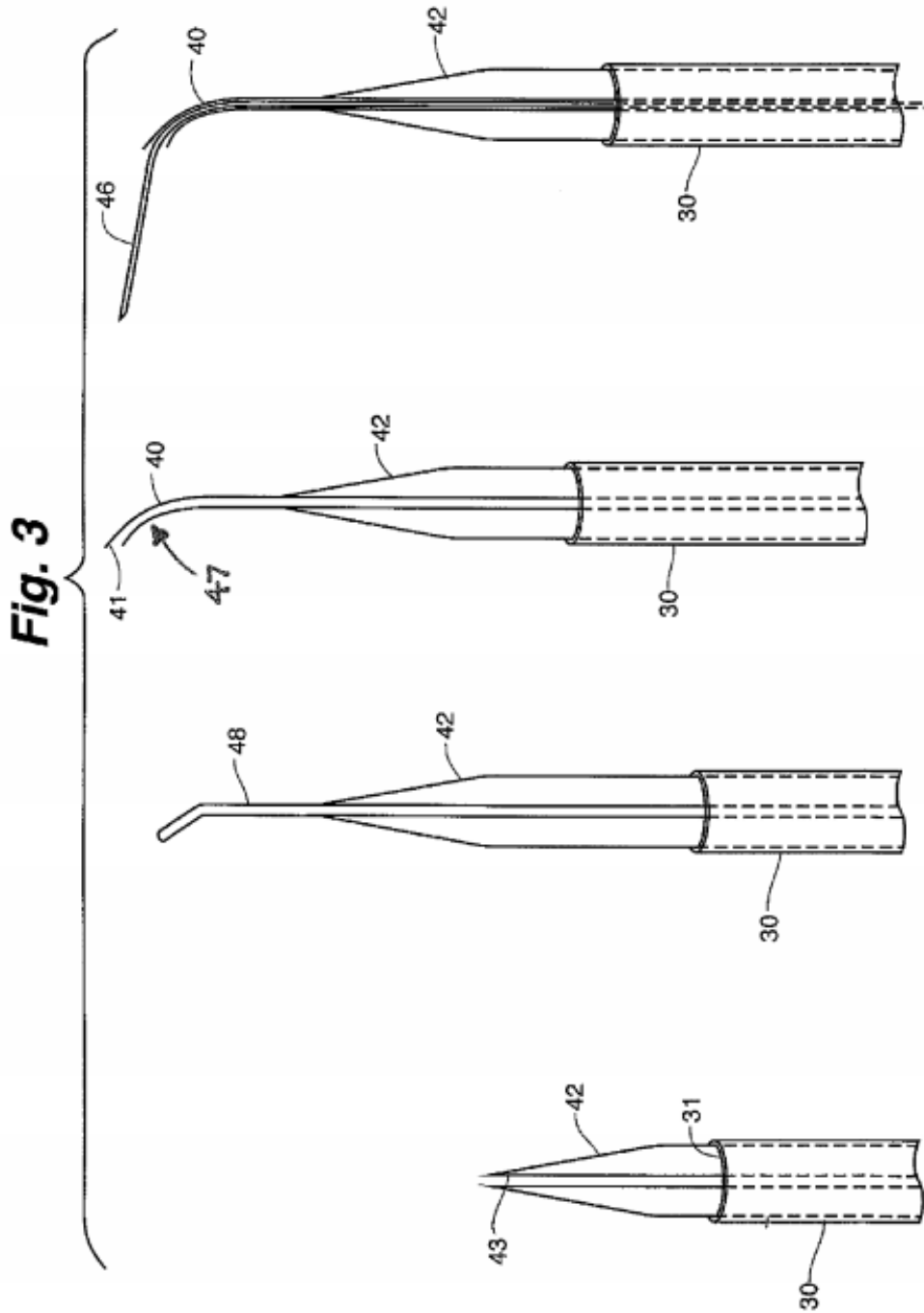


Fig. 4

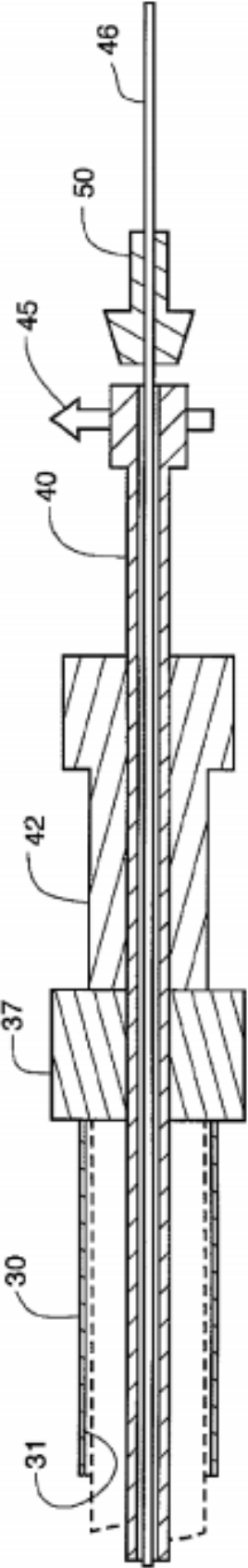


Fig. 5

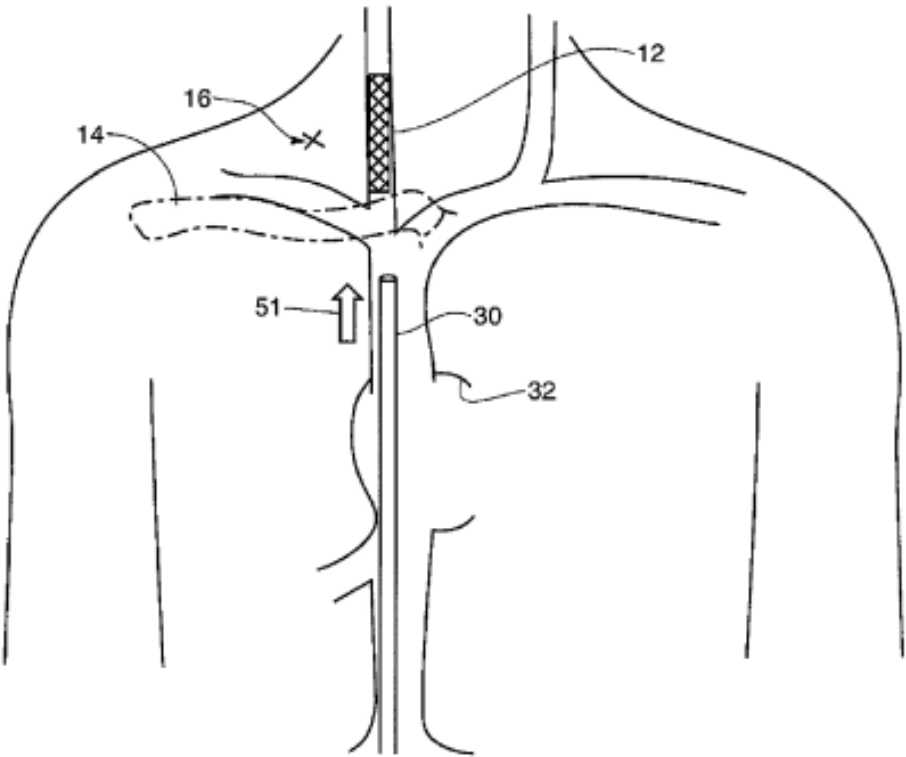


Fig. 6

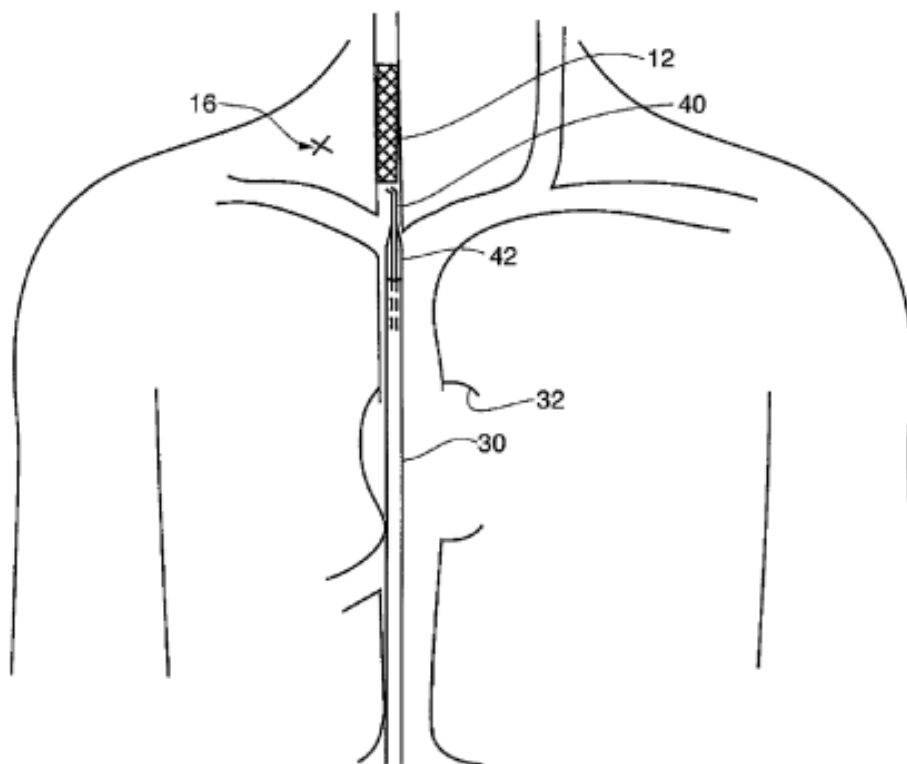


Fig. 7

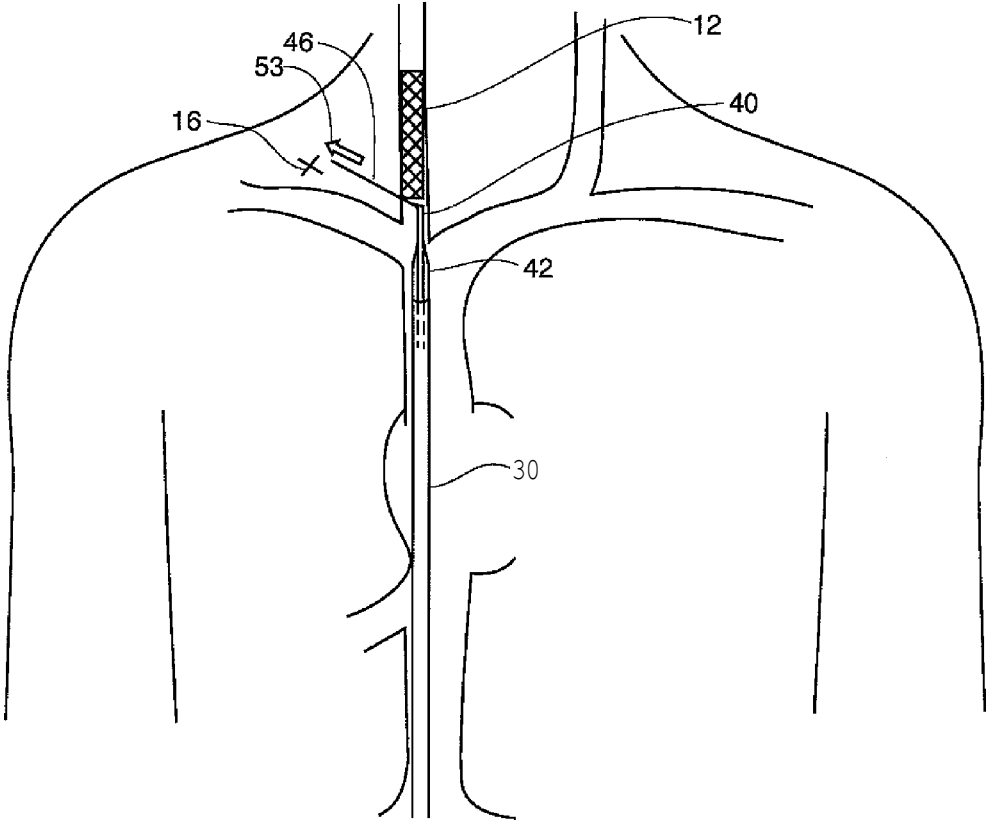


Fig. 8

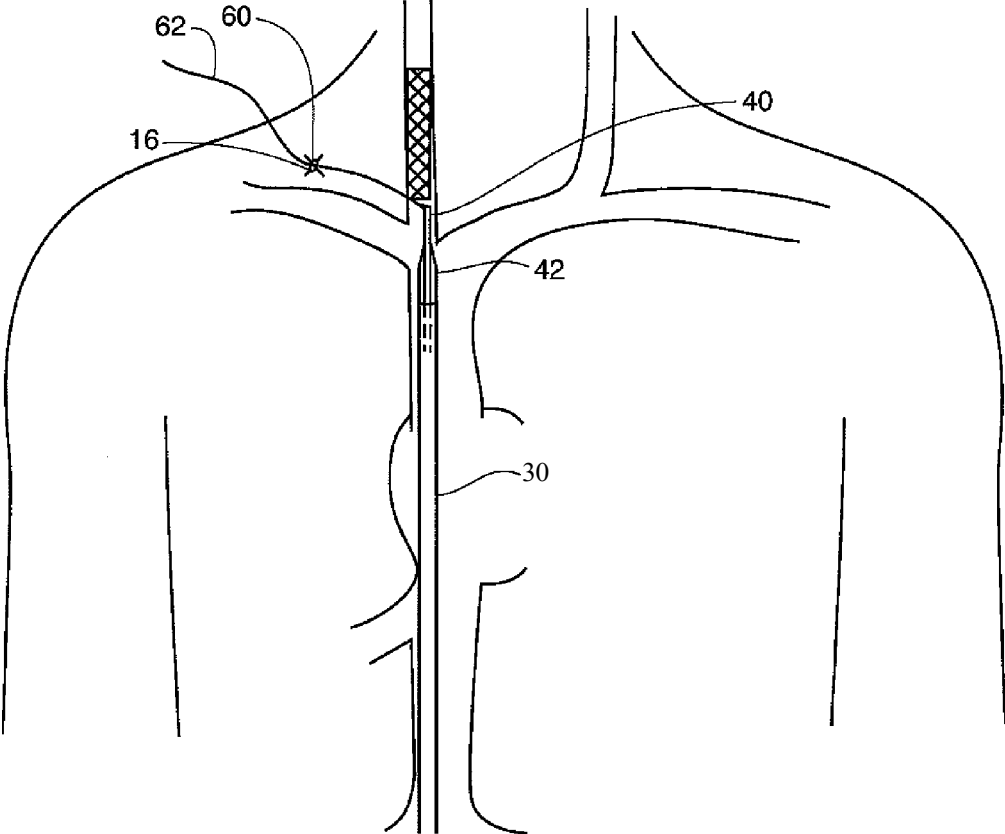


Fig. 9

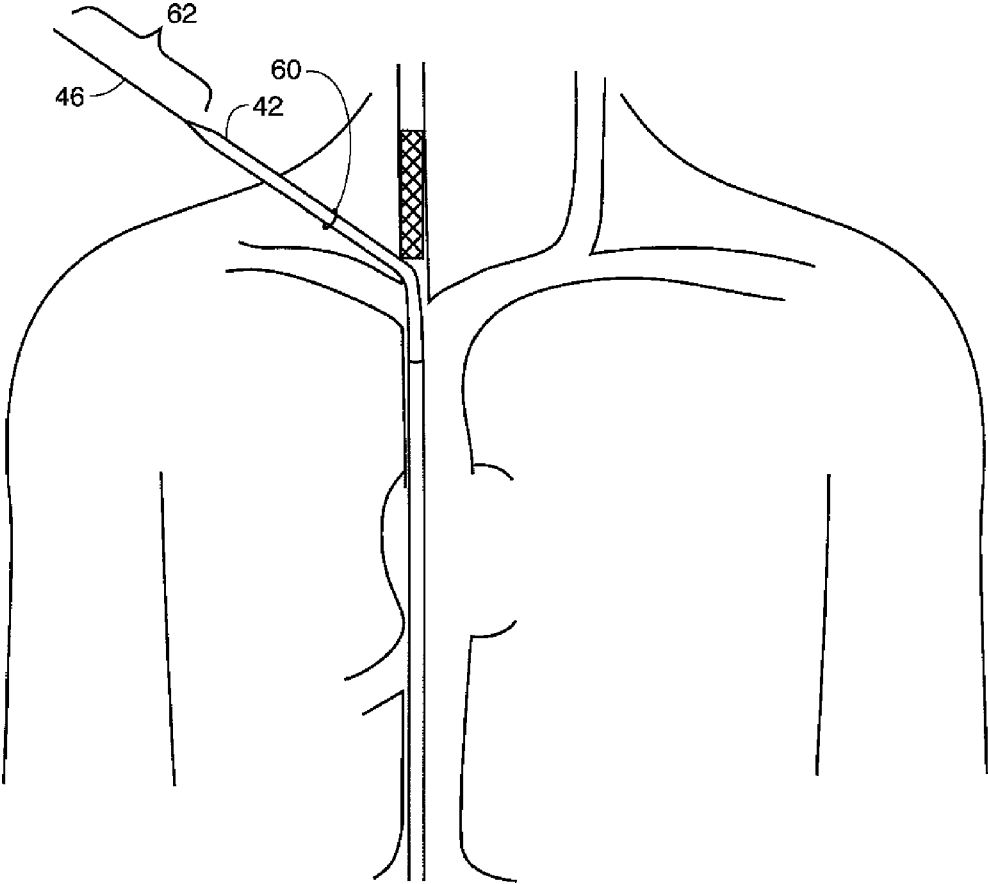


Fig. 10

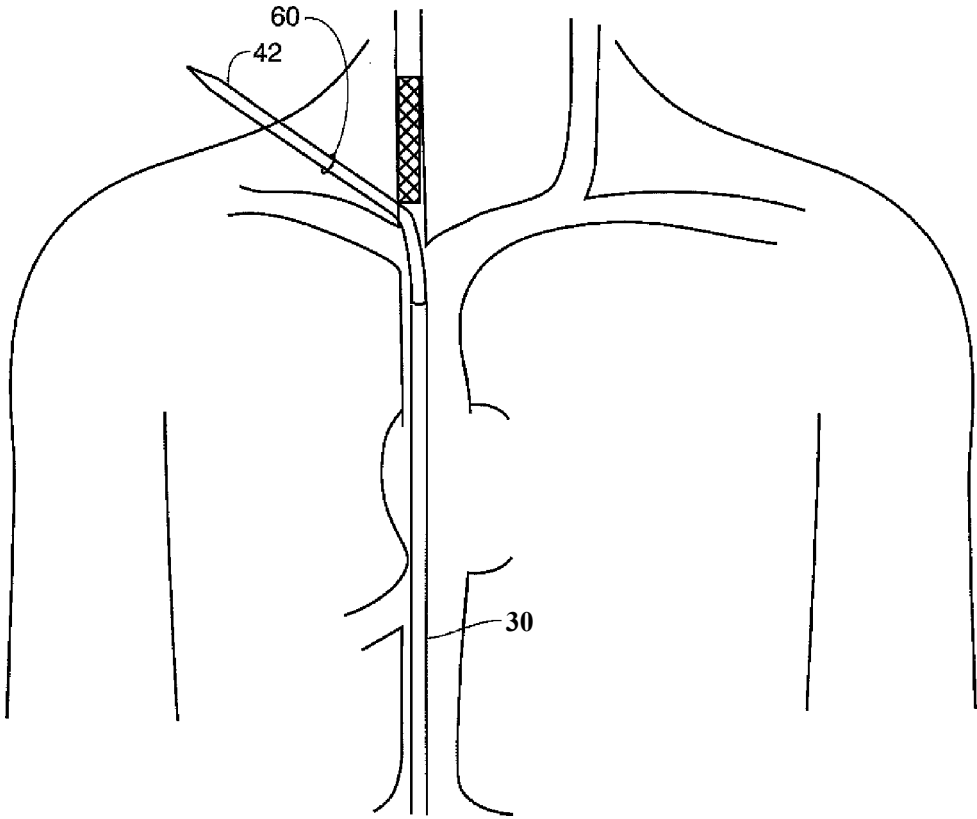
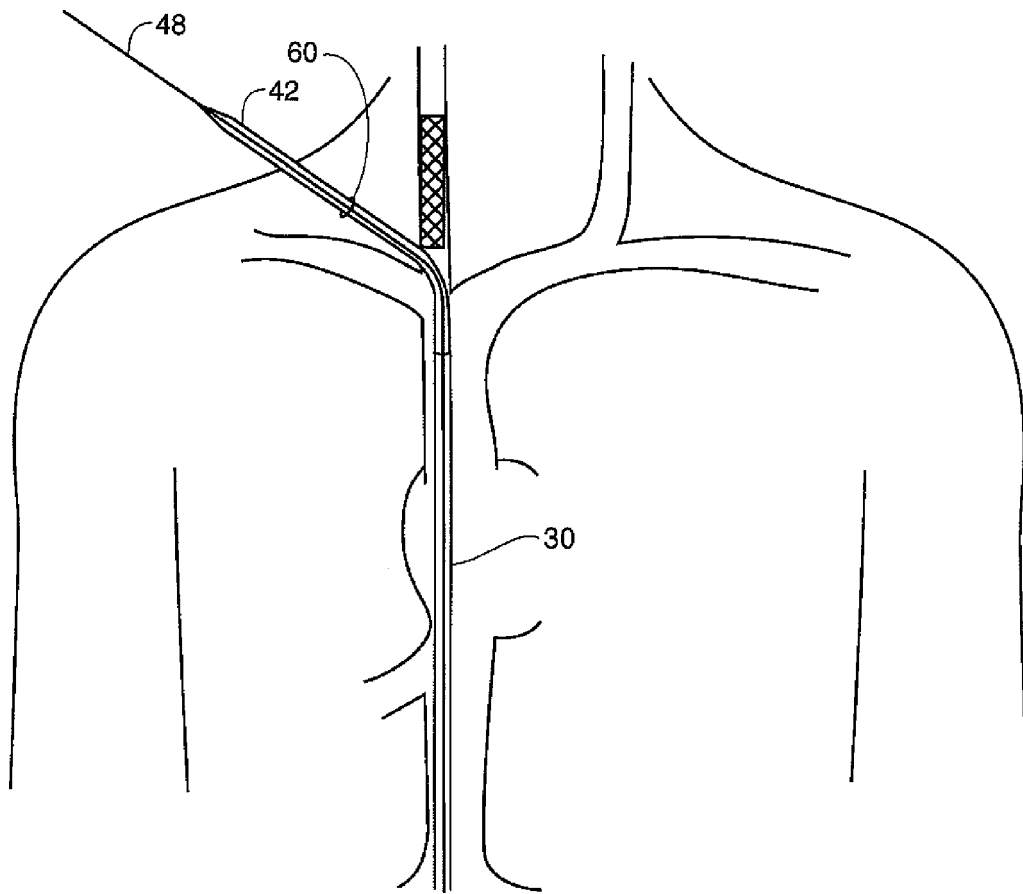


Fig. 11



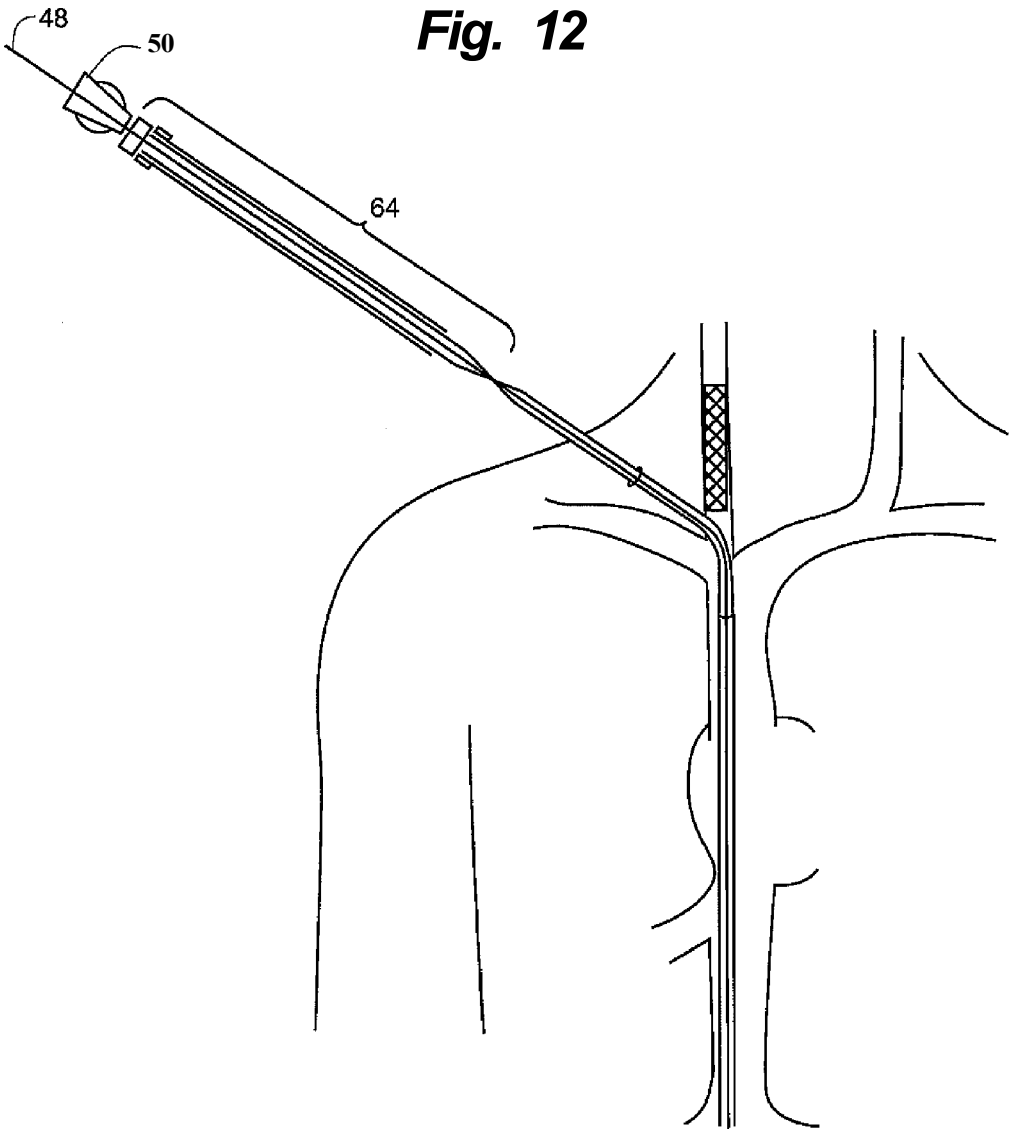


Fig. 13

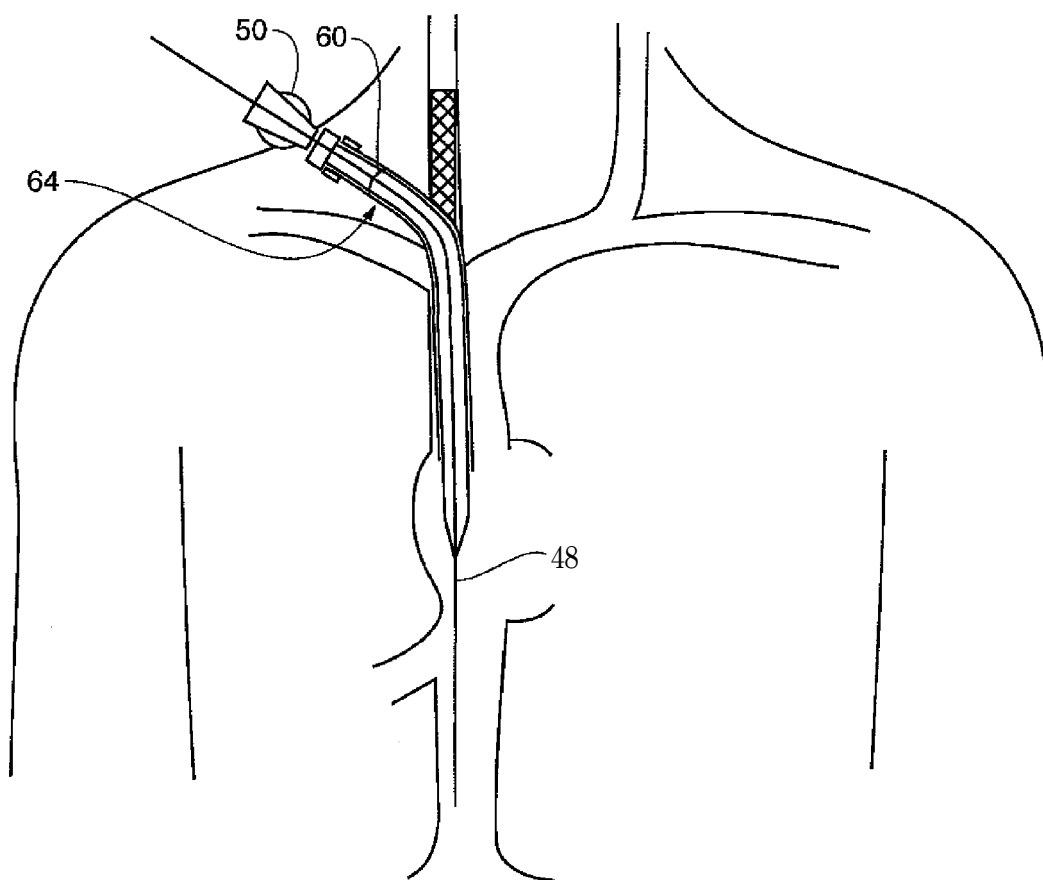


Fig. 14

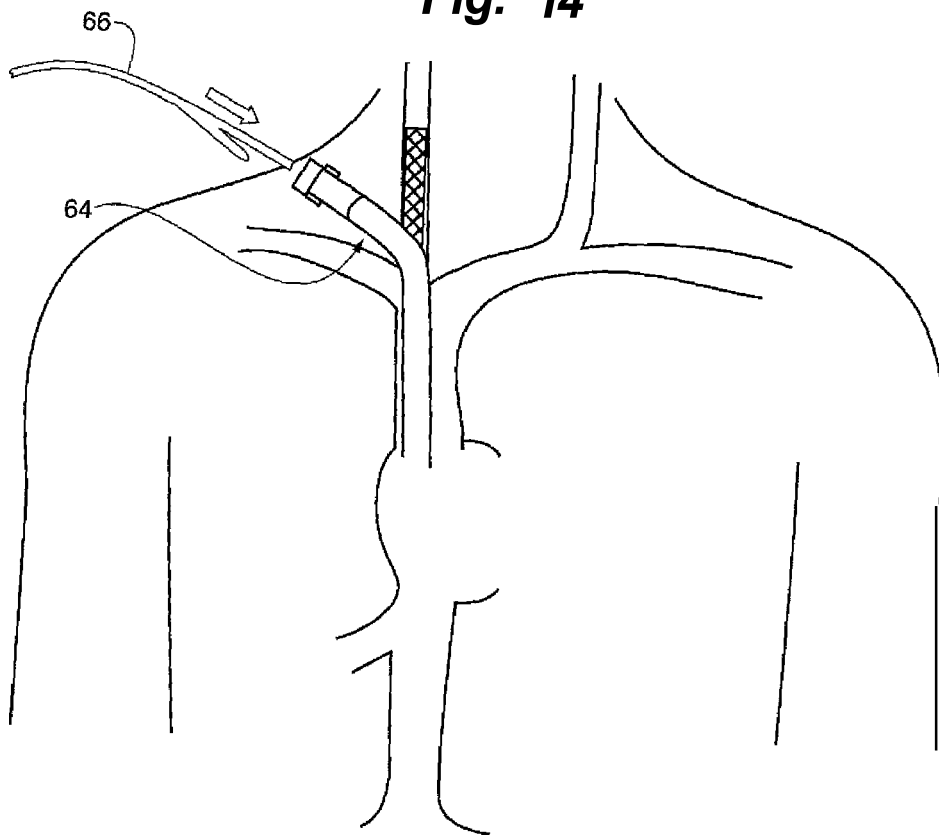
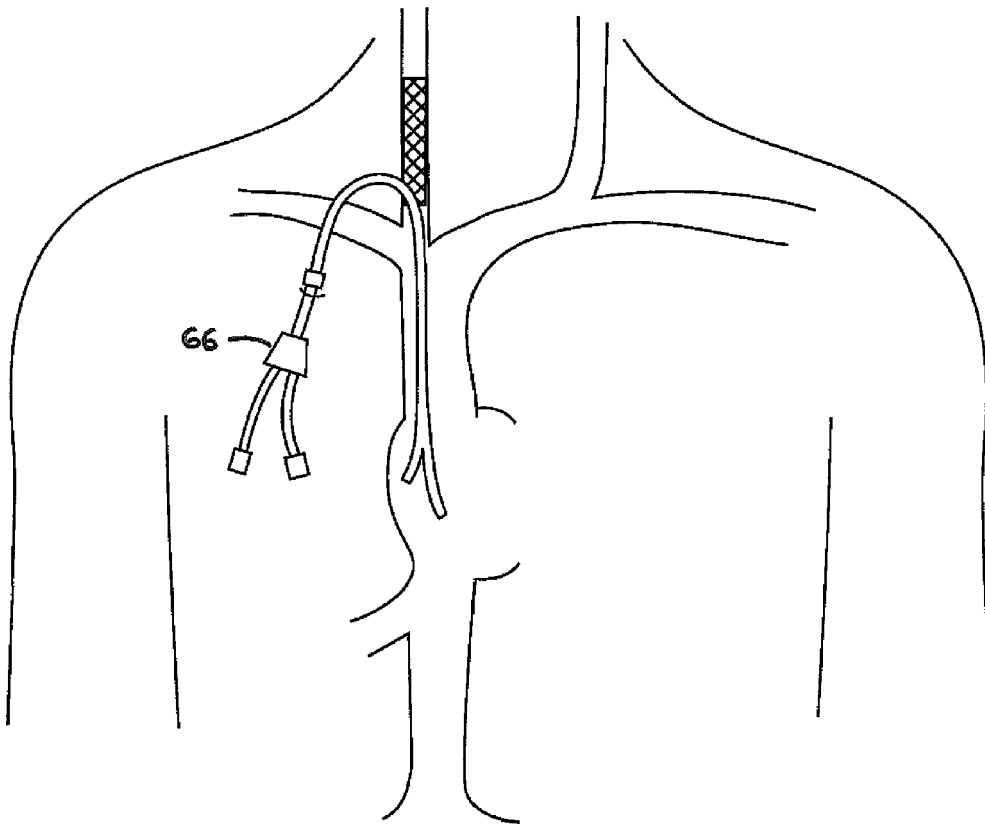


Fig. 15



CENTRAL VENOUS ACCESS SYSTEM

CROSS REFERENCE TO RELATED CASES

The present application is a division of U.S. patent application Ser. No. 12/958,702 filed Dec. 2, 2010, which claims the benefit of both U.S. Provisional Application 61/363,436 entitled "CENTRAL VENOUS ACCESS METHOD, SYSTEM and DEVICES" filed 12 Jul. 2010; and U.S. Provisional Application 61/266,298 entitled "INSIDE/OUT CENTRAL VENOUS ACCESS and APPARATUS" filed 3 Dec. 2009. The entire contents of each of the above-referenced disclosures are specifically incorporated herein by reference without disclaimer.

BACKGROUND OF THE INVENTION

Central venous access (CVA) is one of the most commonly performed procedures in medicine. CVA is vital to many patients with acute and chronic illness. Hemodialysis and cardiac pacing are examples of life-sustaining therapies that would not be possible without central venous access.

CVA is typically obtained by using a large gauge needle to directly puncture first the skin and then one of the four large upper body veins, for example, the right or left internal jugular vein, or the right or left subclavian vein. After puncture, a guidewire is introduced through the needle and advanced into the central circulation. The channel is then dilated and a catheter or other medical device is advanced into the superior vena cava (SVC) or right atrium (RA).

Although central venous access is usually a straightforward procedure, there can be both short term and long term complications. Immediate risks include bleeding due to inadvertent puncture of carotid or subclavian arteries, and pneumothorax due to unintended puncture of a lung. These complications occur because central veins lie deep beneath the skin and are therefore not visible to the operator. As a result, there is often uncertainty about the location, depth and entry angle of the puncture needle, even when ultrasound guidance is used. The long-term risks of central access include venous occlusion, which can occur within days and is a common problem in patients requiring repeated access or semi-permanent access. Chronic venous occlusions occur when thrombus forms around a catheter or pacing lead, and then organizes into dense fibrous tissue that permanently obliterates the vessel lumen.

When confronted with occlusion of a central vein, physicians usually utilize one of the remaining veins in the upper body. The process can continue until all four central veins have been obliterated. However, once all four upper body central veins are lost the patient can have a life threatening access crisis.

SUMMARY OF THE INVENTION

The method is carried out by intravascular navigation of a catheter system that includes specialized devices serving multiple functions. An exit point target site is identified for example near the clavicle on the exterior of the patient's body. The specialized set of intravascular devices in the catheter system are navigated from a remote entry point for example, in the groin to a position proximate the desired exit point target site. A very sharp needle wire is pushed through the catheter system and is directed by the catheter system in a defined and desired direction. Passage of this needle wire forms an extra-vascular tissue track from the vessel to the skin near the exit point target site.

With the needle wire pushed through the skin and exteriorized, companion devices are pushed and/or pulled through the tissue track enlarging it and preparing it for the placement of an access port or pacing lead or the like. The combination of pushing and pulling motions enabled by the catheter system allows for the safe and quick access or re-acquisition of a lost access site to the central venous system. In many instances the ability to work close to thrombus and near occlusions with great precision allows the recovery or salvage of an otherwise lost venous access location, which is a significant benefit to the patient.

DESCRIPTION OF THE DRAWINGS

In the several figures of the drawings, identical reference numerals are used to identify identical or equivalent structure wherein:

FIG. 1 is a schematic diagram showing a portion of the venous system of a patient;

FIG. 2A is a plan view schematic diagram showing the use of a catheter system to access the central venous system;

FIG. 2B is a cross-sectional schematic diagram showing a side view of the system of FIG. 2A;

FIG. 3 is a schematic representation of the distal ends of elements of the catheter system;

FIG. 4 is a schematic diagram showing an assembly of the proximal ends of the catheter system;

FIG. 5 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 6 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 7 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 8 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 9 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 10 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 11 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 12 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 13 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system;

FIG. 14 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system, and;

FIG. 15 is a schematic depiction of a step in the process and illustrates the function of an element of the catheter system.

DETAILED DESCRIPTION OF THE INVENTION

One of the most clinically significant uses of the devices and methods of this invention pertains to right-sided supraclavicular access because it combines the preferred location for long-term catheters, the most common site of chronic venous occlusions, and the most straightforward application of the invention. Therefore this procedure has been selected as an illustrative but not limiting example of the techniques and suitable hardware implementations of the catheter sys-

tern invention. The invention is illustrated in the context of a patient having an occluded right internal jugular vein which is recovered by use of the method and catheter system to place a new access point near the one lost to the occlusion. In contrast to the conventional practice that would sacrifice companion vessels, the illustration achieves re-entry very near a lost CVA location.

FIG. 1 shows the context of the invention and presents the interventional path with respect to certain anatomic reference points. FIG. 2A and FIG. 2B should be considered together and together they show the placement of the rigid guide catheter work station with regard to preferred anatomic reference points. FIG. 2A also shows the proximal end portions of elements of the catheter system extending out of the patient's body. FIG. 3 shows the distal end portions of catheter system elements. FIG. 4 shows the proximal ends of catheter systems elements. The intermediate portions of the catheter elements are not shown for clarity but they should be understood to continue from the distal to the proximal ends and have overall lengths suitable for the size of the patient, and will be on the order of 200 cm overall or more for an adult case. FIG. 5 through FIG. 15 depicts steps in an illustrative fashion of a method of using the catheter system.

FIG. 1 shows a patient 10 with an occluded right internal jugular vein indicated by the cross-hatched occlusion in the vessel at reference numeral 12. The method and devices of the invention are used to re-acquire access to the central venous system through an exit point target location 16 near and slightly above the collar bone or clavicle 14. Beginning at a remote entry point 18 near a large femoral vein in the groin of the patient, the interventional path is seen as a dashed line at reference numeral 20. In practice the surgeon will use conventional techniques to enter the femoral vein then introduce the inventive catheter system and use it to follow the interventional path 20 forming an exit through the skin of the body near the clavicle at the exit point 16 in this illustrative description. Once an appropriate tissue track is established between the exit location 16 and the central venous system the tissue track will be prepared for the delivery of a conventional CVA access port or other device concluding the access procedure.

FIG. 2A is a schematic illustration depicting the placement of the rigid guide catheter work station 30 placed along the interventional path with the distal tip 33 of the work station located above the right atrium 32 at about the level of the ostium of the azygos vein seen at 36. The exit target location is shown at 16 and the remote entry point is shown at 18. Proximal portions of the catheter system extend out of the groin area and they are collectively labeled 17. The physician manipulates these proximal ends of elements of the catheter system rotating, retracting and advancing them to navigate through the vasculature, while observing the locations of the distal ends of the devices under fluoroscopy.

FIG. 2B is a schematic cross section of the patient with anatomic landmarks called out in the figure showing the placement of the rigid guide catheter work station 30, and is a side view of FIG. 2A. The figure shows successful deflection anteriorly of the rigid guide catheter work station 30 at the junction of the IVC and RA 32. This places the distal tip 33 of the workstation against the anterior wall of the SVC. This forces or biases the distal tip 33 against the wall of the vessel and also protects posterior structures from involvement with the catheter system. Once this placement is achieved the work station 30 remains relatively stationary during the rest of the procedure until it is ultimately removed from the body.

FIG. 3 shows the distal tips of various elements of the catheter system assembled in various configurations or combinations in several panels. The relatively long rigid guide catheter work station 30 can support various devices within its working lumen 31. It is expected that suitable performance can be achieved by manufacturing the rigid guide catheter 30 with conventional techniques well known in the art in a diameter of about SF permitting the device to be delivered through an SF introducer. Both metal and braided structures are expected to be suitable.

In the figure the dilation stylet 42 is shown within the lumen 31 of the rigid guide catheter work station 30. The dilation stylet 42 is free to move within the lumen 31. Depending on the point in procedure, the central working lumen 43 of the dilation stylet 42 may carry and support either the canalization wire 48 or the needle wire directional guide 40. The needle wire directional guide 40 has a central lumen 41 adapted to receive the needle wire 46. The distal tip of the needle wire 46 is quite sharp and acts like a trocar to cut and divide tissue as it is pushed. The stiffness of the device and its sharpness must be selected so that it can be pushed through tissue. A sharpened nitinol .014 wire has approximately the correct properties for the needle wire. Note as well that the distal tip of the needle wire directional guide 40 forms a gentle curve 47 to direct and deflect the needle wire 46 in a specific direction. It is expected that this portion of the device will be manufactured from a shape memory material such as nitinol, with the gentle curve 47 formed where the needle wire directional guide 40 emerges from the distal tip of the dilation stylet 42. The gentle curve will direct the needle wire through an angle near 90 degrees or so.

FIG. 4 shows the proximal ends of some of the components assembled into working configurations. In general, the rigid guide catheter work station 30 is placed at the correct location previously described and it remains largely stationary once positioned. An associated valve and flush port with Luer fittings is provided to introduce fluids to clear the devices and occasionally introduce contrast agent. The hemostasis valve and flush valve are shown schematically labeled 37 in the figure. Operation and configuration will be described in more detail in the steps of the method.

FIG. 5 shows a step in the method. As a prelude to this step the entry and exit points on the skin of the patient will be identified and perhaps marked. Next the vasculature will have been accessed via a conventional Seldinger procedure. At this time the rigid guide catheter work station 30 is introduced over a wire into the venous circulation. The straightness of the vasculature and the straightness of the rigid guide catheter workstation 30 allow for navigation, indicated by arrow 51, of the distal end of the catheter workstation 30 to the preferred location in the figure above the right atrium RA 32, below the occlusion 12 and near the clavicle 14.

FIG. 6 shows a step in the method. Next the dilation stylet 42 is advanced out of the rigid catheter work station with the needle wire directional guide 40 to about the occlusion 12 which is typically verified with a contrast injection. The physician manipulating the directional guide arm 45 aims the needle wire directional guide 40 so that the exit port lumen 41 points toward the exit location target site 16 identified on the skin of the patient. Although it is difficult to illustrate the placement of the rigid guide catheter work station 30 it is placed along the anterior wall of the SVC so that the needle wire guide 40 and dilation stylet 42 can be advanced safely toward the occlusion without interfering

with other structures. At this point the needle wire directional guide port or lumen **41** is a short distance from the target exit point **16**.

FIG. 7 shows a step in the method. With aiming completed the physician can push the wire clamp **50** (FIG. 4) to advance the needle wire **46** out of the lumen **41** of the needle wire directional guide **40** and dissect a tissue path toward the clavicle as indicated by force and motion arrow **53** defining an extra vascular tissue track. The rigidity of the rigid catheter work station **30** and its placement allow the reaction forces from the needle wire **46** advancement to be taken up the rigid guide catheter work station and dilation stylet **42** and transferred to the body. The cross section of FIG. 28 also depicts this step with the needle wire **46** actually exteriorized in that figure.

FIG. 8 shows a step in the method. The physician continues to advance the needle wire **46** until it becomes exteriorized at the exit point **16**. The small wound depicted at reference numeral **60** indicates the exit point. The needle wire **46** segment labeled **62** lies outside the body.

FIG. 9 shows a step in the method. The physician will next clamp the needle wire **46** to the dilation stylet **42** with a wire clamp **50** or similar device at the proximal ends of the devices as depicted in FIG. 4, and apply traction to the exterior segment of the needle wire **62** pulling the dilation stylet **42** out of the body through the exit point enlarging the tissue track created by the passage of the needle wire **46**.

FIG. 10 shows a step in the method. The physician may next remove the needle wire **46** and the needle wire directional guide **40** leaving the dilation stylet exteriorized and its central lumen **43** empty.

FIG. 11 shows a step in the method. With the dilation stylet **42** exposed outside the patient the physician may then load or backload a larger gauge wire such as a canalization wire **48** or other guide wire product into the lumen of the dilation stylet. This larger diameter wire will support the next stages of the intervention. The wire size and type is driven mostly by the device that is to be implanted. In the illustrative process a CVA dialysis type port is to be implanted using a conventional introducer sheath **64**.

FIG. 12 shows a step in the method. The physician may load the conventional introducer sheath **64** onto the canalization wire **48** and clamp them together with a wire clamp **50** or the like. The physician has a choice of pulling the introducer along the extra vascular tissue track by tugging on the proximal portions of the dilation stylet and canalization wire or pushing it along the tissue track from the distal end of the system or doing both sequentially or simultaneously.

FIG. 13 shows a step in the method. This figure shows the introducer sheath **64** placed into the central venous system just below the level of the occlusions thus salvaging the location. This figure shows the introducer **64** in place and the physician may remove the rigid guide catheter workstation and related devices from the femoral entry point. The physician may leave a guide wire in place depending on the course of the procedure.

FIG. 14 shows a step in the method. The physician may access the lumen of the conventional introducer **64** to permit the insertion of the dialysis port **66**, though the lumen of the introducer. The precise sequence and hemostasis management will depend on the particularities of the port and the introducer and is not part of the invention apart from illustrating the utility of the procedure.

FIG. 15 shows a dialysis port **66** placed in the patient via the catheter system and method. This port lies in a desirable location that would have been otherwise lost.

The method and suite of devices that make up the catheter system can be used to acquire or re-acquire CVA allowing for the salvage or reuse of vessels and locations that are lost to conventional methods and devices. The method is dependent upon the use of particular devices having specific qualities. The rigid guide catheter work station must be stiff enough to resist reaction forces supplied by the needle wire as it dissects tissue and establishes the tissue track. The needle wire must be stiff enough to dissect tissue when pushed from its proximal end. It must be stiff enough to not wander off course and a very sharp trocar like tip aids in minimizing the force required for dissection. The needle wire directional guide must not whip or kink while it is being aimed under X-ray guidance.

It is also noted that there is much flexibility in the procedure and the system and apparatus used to carry out the method. Some variation in the method will reflect operator preference or the state or size of the patient. For this reason the descriptions herein are intended to be illustrative and not limiting. In a similar fashion the set of specialized medical devices illustrated for carrying out the invention can be supplemented or truncated and certain functions can be carried out with alternate devices. As a consequence the description of the favored hardware should be considered illustrative and not limiting.

What is claimed is:

1. A method for acquiring access to the central venous system of a patient at a target location near an occlusion of a jugular vein, comprising the steps of:

introducing a guide catheter into a blood vessel at a location remote from said occlusion;

advancing a needle wire having a sharp end transvascularily through the guide catheter until its sharp end is adjacent the occlusion;

rotationally adjusting said needle wire until its sharp end is aimed toward the desired skin exit location;

advancing the needle wire to puncture the blood vessel from the inside out at a vascular exit site adjacent the occlusion, thereby establishing a tissue track;

further advancing the needle wire along said tissue track thereby extending said tissue track to puncture the skin from the inside out near said vascular exit site.

2. The method of claim 1 further including the steps of enlarging said tissue track by sequential dilation.

3. The method of claim 2 wherein said enlarging step includes;

clamping said needle wire and said dilation stylet together and drawing them together from said target location.

4. A method for acquiring access to the central venous system of a patient near an occlusion, comprising the steps of:

identifying an exit point target site on the exterior skin of a patient near an occlusion;

introducing a needle wire having a sharp end into a blood vessel at a location remote from said occlusion;

advancing the needle wire through the vasculature until its sharp end is adjacent the occlusion;

aiming the sharp end of the needle wire toward the exit point target; and

advancing the needle wire through the occlusion and through the blood vessel until it becomes exteriorized at the exit point target to establish a tissue track from the blood vessel to the exterior of the patient.

5. The method of claim 4, further comprising introducing a guide catheter with a lumen into the patient at the location remote from the patient and advancing the guide catheter to the occlusion.

6. The method of claim 5, comprising advancing a dilation stylet through the guide catheter to the occlusion, the dilation stylet having a lumen for receiving the needle wire.

7. The method of claim 6, further comprising pulling the dilation stylet out of the body through the exit point to enlarge the tissue track created by the needle wire.

8. The method of claim 6, wherein the step of aiming the sharp end of the needle wire comprises rotating the dilation stylet.

9. A method for acquiring access to the central venous system of a patient near an occlusion, comprising the steps of:

- identifying an exit point target site on the exterior skin of a patient near an occlusion;
- introducing a guide catheter having a first lumen into a blood vessel at a location remote from the exit point target site and advancing the guide catheter to the occlusion;

advancing a dilation stylet having a second lumen through the guide catheter lumen to the occlusion; advancing a needle wire with a sharpened end through the

dilation stylet lumen so that the sharpened end is adjacent the occlusion;

aiming the sharp end of the needle wire toward the exit point target; and

advancing the needle wire through the occlusion and through the blood vessel until it becomes exteriorized at the exit point target to establish a tissue track from the blood vessel to the exterior of the patient.

10. The method of claim 9, wherein the remote site comprises a femoral vein in a groin of the patient.

11. The method of claim 9, further comprising placing an introducer sheath in the tissue track.

12. The method of claim 9, further comprising pulling the dilation stylet out of the body through the exit point to enlarge the tissue track created by the needle wire.

13. The method of claim 12, further comprising introducing a canalization wire into the dilation stylet.

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