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Page 1
1
          UNITED STATES PATENT AND TRADEMARK OFFICE
             BEFORE THE PATENT TRIAL AND APPEAL BOARD
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 3
     MEDTRONIC, INC., AND MEDTRONIC
     VASCULAR, INC.,
 4
                Petitioners,
5
           vs.
6
     TELEFLEX INNOVATIONS S.A.R.L.,
7
                Patent Owner.
8
9
           IPR2020-00126 (Patent 8,048,032 B2)
           IPR2020-00127 (Patent 8,048,032 B2)
           IPR2020-00128 (Patent RE45,380 E)
10
           IPR2020-00129 (Patent RE45,380 E)
11
           IPR2020-00130 (Patent RE45,380 E)
           IPR2020-00132 (Patent RE45,760 E)
12
           IPR2020-00134 (Patent RE45,760 E)
           IPR2020-00135 (Patent RE45,776 E)
13
           IPR2020-00136 (Patent RE45,776 E)
           IPR2020-00137 (Patent RE47,379 E)
14
           IPR2020-00138 (Patent RE47,379 E)
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16
               REMOTE VIDEOTAPED DEPOSITION OF
17
                     STEPHEN BRECKER, M.D.
18
19
                January 19, 2021
     DATE:
20
                5:03 a.m. (Central)
     TIME:
                Veritext Virtual Videoconference
21
     PLACE:
22
23
24
     PAGES:
                     1 to 180
                     MW 4402842
     JOB NO.:
25
     REPORTED BY:
                    Merilee Johnson, RDR, CRR, CRC, RSA
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Page 2 1 APPEARANCES	Pag
(All appearing remotely via videoconference)	1 EXHIBITS
2 3 ON BEHALF OF THE PETITIONERS:	2 (Continued)
4 ROBINS KAPLAN LLP BY: Sharon E. Roberg-Perez, Esq.	3 Exhibit 1026 United States Patent No. 21
5 Cyrus A. Morton, Esq.	4 5,489,278,
Ryan E. Dornberger 6 800 LaSalle Avenue	5 Date of Patent: February 6, 1996
Suite 2800 7 Minneapolis, Minnesota 55402	6 Exhibit 1055 Catheterization and 111
Phone: (612) 349-8500	7 Cardiovascular Interventions,
8 Email: SRoberg-Perez@RobinsKaplan.com Email: CMorton@RobinsKaplan.com	8 dated November 2004
9 Email: RDornberger@RobinsKaplan.com	9 Exhibit 1900 Declaration of Stephen Jon David
ON BEHALF OF THE PATENT OWNERS:	Brecker, MD, FRCP, FESC, FACC
11 DORSEY & WHITNEY, LLP	Submitted in Support of
12 BY: Kenneth E. Levitt, Esq. 50 South Sixth Street	Petitioner's Opposition to Patent
3 Suite 1500	Owner's Motion to Amend,
Minneapolis, Minnesota 55402 4 Phone: (612) 340-2600	14 Case Nos. IPR2020-00126,
Email: Levitt.Kenneth@Dorsey.com	
-and-	<u></u>
6 CARLSON, CASPERS, VANDENBURGH,	16 U.S. Patent No. 8,048,032
7 LINDQUIST & SCHUMAN, PA BY: J. Derek Vandenburgh, Esq.	17 Exhibit 1901 Declaration of Stephen Jon David 1
8 225 South Sixth Street	18 Brecker, MD, FRCP, FESC, FACC
Suite 4200 9 Minneapolis, Minnesota 55402	Submitted in Support of
Phone: (612) 436-9600 0 Email: DVandenburgh@CarlsonCaspers.com	20 Petitioner's Opposition to Patent
1	21 Owner's Motion to Amend,
ALSO APPEARED: 2	22 Case Nos. IPR2020-00137,
Greg Smock (Teleflex) 3 Peter Keith (Teleflex)	23 IPR2020-00138, U.S.
Justin Bond (Videographer)	24 Patent No. RE47,379
24 25	25
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1 INDEX	1 EXHIBITS
2	2 (Continued)
3 WITNESS: STEPHEN BRECKER, M.D. PAGE	3 Exhibit 1902 Declaration of Stephen Jon David 1
4 Examination by Mr. Levitt 8	4 Brecker, MD, FRCP, FESC, FACC
5	5 Submitted in Support of
6 SPECIAL INSTRUCTIONS:	6 Petitioner's Opposition to Patent
	7 Owner's Motion to Amend.
7 Page 154, Line 19 8	8 Case Nos. IPR2020-00128,
	9 IPR2020-00129,
9 EXHIBITS	9 IPR2020-00129, 10 IPR2020-00130,
1 EVHIDITG MARKED AND FIRST DEFENDED TO BACE	<u></u>
1 EXHIBITS MARKED AND FIRST REFERRED TO: PAGE	11 U.S. Patent No. RE45,380
2 Exhibit 1007 United States Patent No. 165	12 Exhibit 1903 Declaration of Stephen Jon David 1
3 7,736,355 B2,	Brecker, MD, FRCP, FESC, FACC
4 Date of Patent: June 15, 2010	Submitted in Support of
5 Exhibit 1008 United States Patent No. 22	Petitioner's Opposition to Patent
	Owner's Motion to Amend,
	17 Case Nos. IPR2020-00132,
6 7,604,612 B2,	
7,604,612 B2,Date of Patent: October 20, 2009	18 IPR2020-00134,
7,604,612 B2, Date of Patent: October 20, 2009	
6 7,604,612 B2, 7 Date of Patent: October 20, 2009 8 Exhibit 1009 United States Patent No. 44 9 5,439,445,	18 IPR2020-00134,
6 7,604,612 B2, 7 Date of Patent: October 20, 2009 8 Exhibit 1009 United States Patent No. 44 9 5,439,445, Date of Patent: August 8, 1995	18 IPR2020-00134, 19 U.S. Patent No. RE45,760
6 7,604,612 B2, 7 Date of Patent: October 20, 2009 8 Exhibit 1009 United States Patent No. 44 9 5,439,445, 10 Date of Patent: August 8, 1995 11 Exhibit 1025 United States Patent Application 99	18 IPR2020-00134, 19 U.S. Patent No. RE45,760 20
6 7,604,612 B2, 7 Date of Patent: October 20, 2009 8 Exhibit 1009 United States Patent No. 44 9 5,439,445, 10 Date of Patent: August 8, 1995 11 Exhibit 1025 United States Patent Application 99 12 No. 2005/0015073 A1,	18 IPR2020-00134, 19 U.S. Patent No. RE45,760 20 21
7,604,612 B2, Date of Patent: October 20, 2009 Exhibit 1009 United States Patent No. 44 9 5,439,445, Date of Patent: August 8, 1995 Exhibit 1025 United States Patent Application 99	18 IPR2020-00134, 19 U.S. Patent No. RE45,760 20 21 22



	Page 6		Page 8
1	EXHIBITS	1	appreciate you've been deposed before a number of
2	(Continued)	2	times, so I won't go through the preliminaries. I
3	Exhibit 1904 Declaration of Stephen Jon David 112	3	would only say that if you get to a point where you
4	Brecker, MD, FRCP, FESC, FACC	4	need a break, and I appreciate the time difference
5	Submitted in Support of		as well, just let me know. It won't be a problem.
6	Petitioner's Opposition to Patent	6	STEPHEN BRECKER, M.D.,
7	Owner's Motion to Amend,		
8	Case Nos. IPR2020-00135,	8	EXAMINATION
9	IPR2020-00136,	_	BY MR. LEVITT:
10	U.S. Patent No. RE45,776	10	Q. Dr. Brecker, is there a difference between
11	Exhibit 2222 Brochure: Pronto V3 Extraction 150		a lesion in a saphenous graft and a lesion that's
12	Catheter		not in a saphenous graft?
	8	13	A. So there can be a difference. They're all
	Exhibit 2231 Drawing by Dr. Stephen Brecker 155		atheromatous lesions; that's what we're talking
15			about. Lesions in vein grafts traditionally have
16			been viewed as having more embolic potential.
17		17	Q. What do you mean they having more embolic
18			protection?
19		19	A. No, I said they have more embolic
20			potential.
21		21	Q. Potential. I'm sorry.
22		22	And why do they have more embolic
23		23	potential?
24		24	A. Well, it's not a rule. All I'm saying is
25		25	that lesions in vein grafts can have a higher
	Page 7		Page 9
1	Page 7 (PROCEEDINGS, 01/19/2021, 5:03 a.m.)	1	Page 9 burden of friable material and also thrombus.
1 2	-		- 1
2	(PROCEEDINGS, 01/19/2021, 5:03 a.m.)	2	burden of friable material and also thrombus.
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2 3 4 5 6 7 8	(PROCEEDINGS, 01/19/2021, 5:03 a.m.) THE VIDEOGRAPHER: Good morning. Today is January 19, 2021. The time is 5:03 a.m., and we are on the record. Today we'll take the videotaped deposition in Case No. IPR2020-00138. This deposition is being held remotely.	2 3 4 5 6 7 8	burden of friable material and also thrombus. That's not to say that you couldn't get that type of lesion in a native vessel. Q. Is there a difference in the nature of the friable material from a lesion in a vein versus a normal vessel? A. Well, again, you're it's not a
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22	(PROCEEDINGS, 01/19/2021, 5:03 a.m.) THE VIDEOGRAPHER: Good morning. Today is January 19, 2021. The time is 5:03 a.m., and we are on the record. Today we'll take the videotaped deposition in Case No. IPR2020-00138. This deposition is being held remotely. Counsel, please state your appearance and affiliation for the record. MR. LEVITT: Good morning. I'm Ken Levitt with Dorsey and Whitney appearing on behalf of Teleflex. With me today is Derek Vandenburgh of the Carlson Caspers firm, Pete Keith and Greg Smock of Teleflex. I would just note for the record that I believe this is being done in connection with a number of IPRs, but I believe the court reporter already has the caption for it. MS. ROBERG-PEREZ: On behalf of petitioner, Medtronic, Sharon Roberg-Perez from Robins Kaplan. With me are my colleagues Cy Morton	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23	burden of friable material and also thrombus. That's not to say that you couldn't get that type of lesion in a native vessel. Q. Is there a difference in the nature of the friable material from a lesion in a vein versus a normal vessel? A. Well, again, you're it's not a hard-and-fast division. It's simply that lesions in vein grafts can be, and are recognized as having, a higher potential for friability and embolization. That is not to say that you couldn't have the most straightforward lesion in a vein graft and an incredibly friable thrombotic lesion in a native vessel. Part of it might relate to the caliber of the vessel, but also the atheromatous process. But it's not that lesions in native vessels are like this and lesions in vein grafts are like that. It's not that they are different. It's not a different disease. Q. Can you explain what a saphenous vein graft



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1 discussing -- a coronary artery bypass graft, where

- 2 you take a length of normal vein from a patient's
- 3 leg and use it as a graft, suturing the top end to
- 4 the aorta and the bottom end to the coronary
- 5 vessel. The structure is a vein. And there are
- 6 differences between the wall of an artery and the
- 7 wall of a vein.
- 8 You can also use vein grafts for other
- 9 indications. You can use segments of vein grafts
- 10 just as a -- sorry, segments of vein just as a
- 11 patch, and you can use it in treating other parts
- 12 of the vascular system.
- 13 Q. So generally speaking, a segment of vein is
- 14 moved from the leg to the coronary context in order
- 15 to go around some lesion that, for whatever reason,
- 16 isn't being treated directly?
- 17 A. You're correct. It's used to bypass a
- 18 lesion, but it's the alternative form of -- this is
- 19 coronary artery bypass surgery, so that's the
- 20 treatment that's being given.
- 21 Q. How does thrombus differ from embolic
- 22 material?
- 23 MS. ROBERG-PEREZ: Objection. Form.
- 24 A. Well, thrombus is a blood clot, in its
- 25 simplest term. Embolic material is a term used to

- 1 coronary vessel is blood clot.
- Q. Would it be fair to say that embolic
- 3 material released during a stenting procedure is
- 4 typically more particulate in nature than thrombus?

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- 5 MS. ROBERG-PEREZ: Objection. Form.
- 6 A. Not necessarily. It could be. Might not 7 be.
- 8 Q. Is it fair to say that embolic material
- 9 that's released during a stenting procedure is
- 10 typically carried into the bloodstream?
- 1 A. Well, it's carried downstream.
- 12 Q. Let's talk about suction catheters for a
- 13 few minutes. Dr. Brecker, have you ever put a
- 14 stent catheter through a suction catheter?
- 15 A. So I've been asked this several times in
- 16 previous depositions, and my answer is the same: I
- 17 have not.
- 18 Q. So let's say, hypothetically, that you
- 19 wanted to put a stent catheter through a suction
- 20 catheter such as Itou. If you were to put the
- 21 suction catheter in and suction, and then advance
- 22 the stent catheter through the suction catheter, is
- 23 it fair to say you would push residual embolic
- 24 material downstream into the bloodstream?
- 25 A. So could you just repeat the sequence to me

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- 1 describe material that moves from one portion of
- 2 the body to another. And in a general term, there
- 3 are a large number of different types of things
- 4 that can embolize that doesn't necessarily have to 5 be thrombus.
- 6 Q. One of which is a lesion?
- 7 A. No, not -- I wasn't thinking of that. I
- 8 think your question was what -- how does it differ
- 9 from embolic material.
- 10 So embolic material can be many different
- 11 things: blood clots in orthopedic surgery; you can
- 12 have fat embolism, the fat can embolize as the
- 13 bones are being manipulated; if air is introduced
- 14 into the circulation in an angiographic procedure,
- 15 you can get air embolism.
- So when you say "lesion material," I'm not
- 17 completely sure -- if you mean in a coronary artery
- 18 do you get embolization of more than just blood
- 19 clots, the answer is yes. In a coronary lesion,
- 20 whether it's in a native vessel or a vein graft,
- 21 you could get embolization of blood clots, of some
- 22 plaque material, some cholesterol, fibrin.
- Many -- there's components to the lesion,
- 24 and some of that could embolize. I would think
- 25 that the largest component of an embolus in a

- 1 again?
- Q. Sure. If you were to insert a suction
- 3 catheter and then use it to suction material, and
- 4 then leaving the suction catheter in, insert a
- 5 stent catheter into the guide catheter and the
- 6 suction catheter, would you then push residual
- 7 material downstream into the bloodstream?
- 8 A. Well, my answer is: Not necessarily.
- 9 There had been teaching of the use of suction and
- 10 aspiration catheters to deliver stents, and
- 11 specific teaching that would have advocated the
- 12 process you described. I think it would depend a
- 13 lot on the nature of the vessel, the nature of what
- 14 you were treating.
- 15 I can envisage a situation where you put
- 16 the suction catheter, get complete clearance of
- 17 whatever you're wanting to clear, got the good
- 18 backflush. You wouldn't necessarily, then,
- 19 embolize anything. It's certainly a theoretical
- 20 possibility, but you wouldn't -- it wouldn't be a
- 21 definite, by any means.
- 22 Q. How would you backflush the suction
- 23 catheter?
- 24 A. Suction.
- 25 Q. Is there still a risk, though, that without



1 removing the suction catheter and flushing it,

- 2 there's going to be residual embolic material in
- 3 the catheter?
- A. It's a possibility. But there had -- there
- 5 was -- there were descriptions of this in
- 6 literature that specifically said not to remove the 7 aspiration catheter.
- So it wasn't -- it wasn't that you would --9 that it couldn't be done; it certainly could. And 10 you would want to, to remove procedural steps.

There would be disadvantages to potentially 11

- 12 removing the aspiration catheter at that point
- 13 because any catheter change brings with it a 14 prolongation of the procedure, which itself can
- 15 lead to blood clot or the introduction of air. And 15 But as I've said, that specific procedure that
- 16 I've seen both of those happen during catheter
- 17 exchange procedures.
- So during an interventional procedure, it's 19 a balance as to the order in which you do things.
- 20 And you certainly wouldn't not simply leave the
- 21 aspiration catheter there to advance a stent if
- 22 that was the appropriate thing to do in the 23 procedure.
- Q. Is it fair to say that if you leave the 25 aspiration catheter in after aspirating out

1 that the aspirational suction catheter can be sized

- 2 such that you can suction with a stent in place.
- So, again, it depends on the relative sizes 4 of the catheters that we're talking about. But as
- 5 a general rule, I would not agree that it means you
- 6 couldn't then suction. It had been specifically
- 7 taught that you could.
- Q. Is it fair to say that having the stent
- 9 catheter in the suction catheter while performing
- 10 the suction would restrict the suction?
 - A. Well, I've answered, I think. It would
- 12 depend on the size of the stent, size of the
- 13 catheter, the nature of what you were sucking.
- 14 It's a possible theoretical point, yes.
- 16 you're describing had been taught in prior art. 17 Q. Is there a typical size stent catheter that
- 18 you advance through a 6 French guide catheter in a
- 19 coronary intervention procedure?
- 20 MS. ROBERG-PEREZ: Objection. Form.
- 21 A. Well, there's a large range of stents. And
- 22 their crossing profiles are documented.
- Q. So if you're using a 6 French guide
- 24 catheter and you have a suction catheter inserted
- 25 through that, and a stent with an .056 crossing

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- 1 thrombotic material, there is a risk that there's
- 2 going to be residual thrombotic material in the
- 3 suction catheter that is then pushed downstream
- 4 when you advance the stent catheter through the
- 5 suction catheter?
- MS. ROBERG-PEREZ: Objection. Asked
- 7 and answered.
- A. I think I've said that, that it's a
- 9 potential risk. But if you've cleared the
- 10 thrombus, you've got good backflush by suction,
- 11 you've got precedent in literature and practice.
- 12 It would not be an absolute contraindication.
- 13 It's a potential risk. You're balancing 14 that against the risk of the catheter exchange,
- 15 prolonging the procedure, that itself, as I said,
- 16 can produce thrombus and introducing air.
- 17 Q. Dr. Brecker, if you were to insert a
- 18 suction catheter and then, before suctioning,
- 19 advance a stent catheter into the suction catheter,
- 20 is it accurate to say that if you were then to
- 21 apply suction to the suction catheter, the presence
- 22 of the stent and stent catheter would inhibit the
- 23 suction?
- A. So that's an interesting question. It's
- 25 dealt with explicitly in prior art, where it says

- 1 profile, is that a workable combination?
- A. I don't know. I haven't -- I haven't
- 3 considered that specifically. If it relates to an
- 4 opinion I've given in a declaration, I'd be happy
- 5 to go to it. I don't think I have considered that
- 6 specific scenario that you're setting out.
- Q. Have you considered the -- are there stent
- 8 catheter and suction catheter combinations where
- 9 inserting stent catheter through the suction
- 10 catheter, and then applying suction to the suction
- 11 catheter, would have reduced suction flow because
- 12 of the presence of a stent catheter inside the
- 13 suction catheter?
- A. So I haven't given an opinion on that
- 15 specific point.
- Q. Sitting here today, you don't have an
- 17 opinion on that?
- A. I haven't considered it. I hadn't -- I
- 19 don't think I've given an opinion in any of the
- 20 declarations that are the subject of today. So I
- 21 haven't done that experimentation. I haven't done
- 22 that exercise of assessing that.
- Q. Okay. So let me ask a different question.
- 24 Dr. Brecker, if you were to put a suction catheter
- 25 in and then advance the stent catheter through the



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