INSTRUCTIONS FOR USE
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Federal (USA) law restricts this device to sale by or on the order of a physician. Only qualified healthcare providers should place, manipulate, declot, revise or explant the device. Carefully read all instructions prior to use. Not Made with Natural Rubber Latex. Adhere to universal precautions when inserting, maintaining or explanting the device.

STERILE (EO) – FOR SINGLE USE ONLY
Each component of the HeRO® Graft is provided double pouched with an outer sterile barrier and is EO sterilized.

STORAGE
To provide maximum protection, store the HeRO Graft components in their original, unopened packages at room temperature. Keep dry and out of direct sunlight. Each component must be used before the use by date printed on the individual labels.

Caution
Use-By Date
Single Use
Non-Pyrogenic
Do Not Resterilize
Sterile Using Ethylene Oxide
Manufacturer
Keep Dry
Keep Away from Sunlight
Do Not Use If Package is Damaged and Consult Instructions for Use
Consult Instructions for Use
For electronic copy scan QR Code, or go to www.merit.com/ifu and enter IFU ID Number. For printed copy, call U.S.A or E.U. Customer Service
Unique Device Identifier
Medical Device

DEVICE DESCRIPTION
The HeRO® (Hemodialysis Reliable Outflow) Graft is a long-term access solution for access-challenged and catheter-dependent patients. HeRO Graft is a fully subcutaneous surgical implant. It provides arterial venous (AV) access with continuous outflow into the central venous system. The HeRO Graft traverses central venous stenosis allowing for long-term hemodialysis access.

HeRO Graft consists of two primary components:
- A proprietary Venous Outflow Component
- A proprietary ePTFE Arterial Graft Component

The Venous Outflow Component has a 5mm inner diameter (ID), 19F outer diameter (OD), and is 40cm long. It consists of radiopaque silicone with braided nitinol reinforcement (for kink and crush resistance) and a radiopaque marker band at the tip. A 10 French Delivery Stylet is packaged with the Venous Outflow Component to aid in placement of the device.

The Arterial Graft Component has a 6mm ID, 7.46mm OD, and is 53cm long, inclusive of the connector (titanium). It consists of an ePTFE hemodialysis graft with FEP beading to provide kink resistance near the connector. The connector has a tapered ID (6mm to 5mm) and attaches the Arterial Graft Component to the Venous Outflow Component. The Arterial Graft Component is cannulated using standard technique according to KDOQI guidelines.

The Accessory Component Kit provides instruments and accessories that may aid in the placement of the HeRO Graft.

The FDA classification name for the HeRO Graft is vascular graft prosthesis.
INTENDED USE/INTENDED PURPOSE
The HeRO Graft is intended for use in maintaining long-term vascular access for chronic hemodialysis patients who have exhausted peripheral venous access sites suitable for fistulas or grafts.

INDICATIONS FOR USE
The HeRO Graft is indicated for end-stage renal disease patients on hemodialysis who have exhausted all other access options. These catheter-dependent patients are readily identified using the KDOQI guidelines as patients who:
- Have become catheter-dependent or who are approaching catheter-dependency (i.e., have exhausted all other access options, such as arteriovenous fistulas and grafts).
- Are not candidates for upper extremity fistulas or grafts due to poor venous outflow as determined by a history of previous access failures or venography.
- Are failing fistulas or grafts due to poor venous outflow as determined by access failure or venography (e.g., fistula/graft salvage).
- Have poor remaining venous access sites for creation of a fistula or graft as determined by ultrasound or venography.
- Have a compromised central venous system or central venous stenosis (CVS) as determined by a history of previous access failures, symptomatic CVS (i.e., via arm, neck, or face swelling), or venography.
- Are receiving inadequate dialysis clearance (i.e., low Kt/V) via catheters. KDOQI guidelines recommend a minimum Kt/V of 1.4.¹

CONTRAINDICATIONS
Implantation of the HeRO Graft is contraindicated if:
- The brachial or target artery inner diameter (ID) is less than 3mm.
- The internal jugular vein (IJV) or target vasculature cannot be dilated to accommodate the 19F HeRO Graft Venous Outflow Component.
- There is significant arterial occlusive disease that would preclude safe placement of an upper extremity hemodialysis access.
- There is known or suspected allergy to device materials (e.g., ePTFE, FEP, silicone, titanium alloys, nickel).
- The patient has a topical or subcutaneous infection associated with the implantation site.
- The patient has known or suspected systemic infection, bacteremia or septicemia.

GENERAL CAUTIONS
- The HeRO Graft is intended for use by physicians trained and experienced in endovascular and surgical interventions and techniques.
- Only qualified healthcare practitioners should place, manipulate, cannulate, declot, revise or explant the device.
- Reuse, reprocess or resterilize. Reuse, reprocessing or resterilization may compromise the structural integrity of the device and/or lead to device failure which, in turn, may result in patient injury, illness or death. Reuse, reprocessing or resterilization may also create a risk of contamination of the device and/or cause patient infection or cross-infection, including, but not limited to, the transmission of infectious disease(s) from one patient to another.
- Use of the HeRO Graft was clinically studied in the IJV. Implantation of the device in other vasculature has NOT been studied and may increase the risk of adverse events not encountered in the clinical trial.

CLINICAL BENEFITS
- Device allows for efficient dialysis
- Enables AV access in patients with central venous stenosis
- Amenable with complete or partial removal or revision
- Device and accessories are compatible with standard imaging modalities

KEY PERFORMANCE CHARACTERISTICS
- A summary of the endpoint and performance data from the U.S. Multi-center pivotal clinical trials is summarized in Table 1 - the performance data from the Clinical trials.

GENERAL WARNINGS
- DO NOT use mechanical/rotational thrombectomy devices (e.g., Arrow-Trerotola PTD®) in the Venous Outflow Component or vessel damage.

GENERAL CAUTIONS
- Only qualified healthcare practitioners should place, manipulate, cannulate, declot, revise or explant the device.
- The HeRO Graft is intended for use by physicians trained and experienced in endovascular and surgical interventions and techniques.
- Adequate daylight should be observed when implanting, cannulating, maintaining or explanting the device.
- DO NOT place the HeRO Graft in the same vessel as a catheter, defibrillator or pacemaker lead.
- To avoid vessel damage, fluoroscopy must be used when inserting the HeRO Graft into the central venous system.
- Monitor the patient for signs of arrhythmia throughout the procedure. To minimize the risk of arrhythmia, DO NOT place the tip of the guidewire into the right ventricle.
- Caution should be used when placing or removing the Venous Outflow Component where stent contact may occur due to the potential for Venous Outflow Component or vessel damage.
- When connecting the Venous Outflow Component to the Arterial Graft Component, verify the Venous Outflow Component is flush with the shoulder of the connector.
- The beading on the Arterial Graft Component provides kink resistance near the connector. DO NOT modify or attempt to peel the beading on the Arterial Graft Component as this could result in damage to the graft.
- DO NOT use mechanical/rotational thrombectomy devices (e.g., Arrow-Trerotola PTD®) in the Venous Outflow Component and/or connector as internal damage may occur to these components.

Venous Outflow Component
- Device and accessories are compatible with standard imaging modalities
- Implantation of the device in other vasculature has NOT been studied and may increase the risk of adverse events not encountered in the clinical trial.
- DO NOT use product if package has been damaged, opened, or the use by date has passed, as sterility may be compromised.

Venous Outflow Component
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- The beading on the Arterial Graft Component provides kink resistance near the connector. DO NOT modify or attempt to peel the beading on the Arterial Graft Component as this could result in damage to the graft.
- DO NOT use mechanical/rotational thrombectomy devices (e.g., Arrow-Trerotola PTD®) in the Venous Outflow Component and/or connector as internal damage may occur to these components.
The HeRO Graft provides an important means of treating patients requiring hemodialysis; however, the potential exists for serious complications including, but not limited to, the following:

**Potential Vascular Graft & Catheter Complications**
- Abnormal healing / skin erosion
- Anastomosis or wound dehiscence
- Device kinking or compression
- Device migration
- Ectasia
- Edema
- Foreign body reaction or rejection
- Graft extravasation
- Bacteremia and non-bacteremic infection
- Partial stenosis or full occlusion of prosthesis or vasculature
- Prosthesis failure
- Pseudoneurysm
- Seroma
- Site pain
- Superior Vena Cava Syndrome
- Vascular graft revision / replacement
- Vascular insufficiency due to steal syndrome

**Potential Intraoperative & Post-Operative Complications**
- Allergic reaction
- Anesthesia
- Bleeding
- Cardiac arrhythmia
- Cardiac tamponade
- Death
- Embolism
- Heart failure
- Hematoma
- Hemorrhage
- Hypotension / hypertension
- Myocardial infarction
- Pneumothorax / hemthorax / hydro-thorax
- Reactions to anesthesia
- Respiratory / cardiac arrest
- Seizus
- Trauma to major vasculature or nerves

**SUMMARY OF HeRO GRAFT CLINICAL EXPERIENCE**

The HeRO Graft was evaluated in a prospective Clinical Study to demonstrate that the device raises no new concerns of safety and effectiveness when used as indicated in patients requiring long-term hemodialysis.

The HeRO Graft was studied in two different patient populations. One was a prospective literature controlled study of HeRO Graft / implant procedure-related bacteremia rates in catheter-dependent subjects (the “bacteremia study”), and the other was a randomized study of HeRO Graft patency in upper arm graft-eligible subjects compared to subjects receiving an ePTFE control graft (the “patency study”).

Fourteen (14) institutions treated 86 subjects with the HeRO Graft. Subjects were required to return for post-operative evaluation at three-month intervals for a minimum of 12 months. Endpoint and performance results are summarized in Table 1.

The study results show that the rate of device / procedure-related bacteremia associated with the HeRO Graft is statistically lower than reported in the literature for tunneled catheters and comparable to that reported in the literature for conventional ePTFE Grafts. HeRO Graft patency and adequacy of dialysis are significantly improved compared to catheter literature and comparable to graft literature.

The HeRO Graft has an associated safety profile that is comparable to existing graft and catheters used for hemodialysis. In this study, no new concerns of safety and effectiveness for a long-term vascular access device were observed. There were no unanticipated events. Serious HeRO Graft and / or procedure-related adverse events by type are summarized in Table 2.

Device-related adverse events occurred at a frequency comparable to both the catheter and graft literature with the exception of bleeding. Of the six (6) bleeding events in the patency study, two (2) were indirectly related to the HeRO Graft implant procedure; in the first patient, coagulopathy was caused by other conditions and bleeding was not unexpected, and in the second patient, a heparin administrative error occurred. Three (3) bleeding events were directly attributed to an earlier generation 22F HeRO Graft Venous Outflow Component, which required an internal jugular venous cut-down. The sixth bleeding event was related to a HeRO Graft explant procedure. There was one (1) device-related death in the patency study due to device-related sepsis complications, a known vascular access complication reported in the literature.

The HeRO Graft was studied in two different patient populations. One was a prospective literature controlled study of HeRO Graft / implant procedure-related bacteremia rates in catheter-dependent subjects (the “bacteremia study”), and the other was a randomized study of HeRO Graft patency in upper arm graft-eligible subjects compared to subjects receiving an ePTFE control graft (the “patency study”).

**TABLE 1: Final HeRO Graft Endpoint & Performance Data**

<table>
<thead>
<tr>
<th>Device/Procedure-Related Bacteremia Rate/1,000 Days</th>
<th>HeRO Graft Bacteremia Study (N=56)*</th>
<th>HeRO Graft Patency Study (N=55)*</th>
<th>Catheter Literature</th>
<th>ePTFE Graft Literature</th>
<th>KDOQI Adequacy of Hemodialysis Guidelines†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Device/Procedure-Related Bacteremia Rate/1,000 Days</td>
<td>0.70/1,000 days (1.45 Upper Confidence Bound (UCB))</td>
<td>0.13/1,000 days (0.39 Upper Confidence Bound (UCB))</td>
<td>2.1/1,000†</td>
<td>0.13/1,000†</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Primary Patency at 6 Months % (n/N)</td>
<td>47.2 (77/164)</td>
<td>48.0 (24/50)</td>
<td>50%†</td>
<td>58%*</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Assisted Primary Patency at 6 Months % (n/N)</td>
<td>94.4 (24/26)</td>
<td>88.0 (44/50)</td>
<td>92%*</td>
<td>89%*</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Secondary Patency at 6 Months % (n/N)</td>
<td>77.8 (28/36)</td>
<td>78.0 (39/50)</td>
<td>53%*</td>
<td>56%*</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Primary Patency at 12 Months % (n/N)</td>
<td>33.3 (12/36)</td>
<td>36.0 (18/50)</td>
<td>36%*</td>
<td>42%*</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Assisted Primary Patency at 12 Months % (n/N)</td>
<td>88.9 (32/36)</td>
<td>84.0 (42/50)</td>
<td>Not Reported</td>
<td>Not Reported</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Secondary Patency at 12 Months % (n/N)</td>
<td>77.8 (28/36)</td>
<td>70.0 (15/50)</td>
<td>37%*</td>
<td>65%*</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Adequacy of Dialysis ±SD</td>
<td>Kt/V</td>
<td>1.7±0.3 [95%CI]</td>
<td>1.6±0.3 [95%CI]</td>
<td>1.29±1.46*</td>
<td>1.37±1.62*</td>
</tr>
<tr>
<td>URR</td>
<td>74.3±3.8 [95%CI]</td>
<td>78.6±6.8 [95%CI]</td>
<td>65-70</td>
<td>70-75</td>
<td>70 Target</td>
</tr>
</tbody>
</table>

1. Procedure-related bacteremia was defined as any bacteremia seeded by the subject’s previous tunneled dialysis catheter (cultured at the time of HeRO Graft implant), any bacteremia that may have been seeded by a pre-existing infection elsewhere in the subject's body possibly making the subject more susceptible to bacteremia in the peri-operative period, or where there is no other source for the bacteremia identified other than the implant procedure. Bacteremia was categorized as device-related when no other source for the infection could be identified.
**TABLE 2: Final HeRO Graft Serious Device and/or Implant Procedure-Related Adverse Events by Type from U.S. Multi-Center Clinical Trials**

<table>
<thead>
<tr>
<th>HeRO Graft Bacteremia Study # Events (N = 38)</th>
<th>HeRO Graft Patency Study # Events/ # Subject (%) (N = 22)</th>
<th>Catheter Literature</th>
<th>ePTFE Graft Literature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding, hemorrhage or hematoma</td>
<td>2/38 (5.3%)</td>
<td>0/52 (1.9%)</td>
<td>76/4209 (1.9%) per Catheter</td>
</tr>
<tr>
<td>Cardiac arrhythmia</td>
<td>3/38 (8.0%)</td>
<td>0/52 (0.0%)</td>
<td>30/422 (6.9%) of ESRD subjects</td>
</tr>
<tr>
<td>Death</td>
<td>1/38 (2.6%)</td>
<td>1/52 (1.9%)</td>
<td>216.7 (249,300)</td>
</tr>
<tr>
<td>Edema (includes swelling)</td>
<td>1/38 (2.6%)</td>
<td>0/52 (0.0%)</td>
<td>5/96 (5.3%) per Catheter</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>3/38 (8.0%)</td>
<td>2/52 (3.8%)</td>
<td>1.1 x 10^9 days</td>
</tr>
<tr>
<td>Infected (non-bacteremia)</td>
<td>0/38 (0.0%)</td>
<td>1/52 (1.9%)</td>
<td>28/566 (4.9%) of ESRD subjects</td>
</tr>
<tr>
<td>Stroke</td>
<td>0/38 (0.0%)</td>
<td>1/52 (1.9%)</td>
<td>0.08-0.080 per year in ESRD subjects</td>
</tr>
<tr>
<td>Vascular insufficiency due to steal syndrome (includes ischemia)</td>
<td>2/38 (5.3%)</td>
<td>1/52 (1.9%)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Wound problems (includes wound dehiscence)</td>
<td>3/38 (8.0%)</td>
<td>0/52 (0.0%)</td>
<td>Not Reported</td>
</tr>
<tr>
<td>Trauma to major veins, arteries, nerves</td>
<td>3/38 (8.0%)</td>
<td>1/52 (1.9%)</td>
<td>18/2123 (0.8%) per Catheter</td>
</tr>
<tr>
<td>Accessory Component Kit</td>
<td>0/38 (0.0%)</td>
<td>0/52 (0.0%)</td>
<td>Not Reported</td>
</tr>
<tr>
<td>Breakage or mechanical failure (prosthesis technical failure)</td>
<td>3/38 (8.0%)</td>
<td>1/52 (1.9%)</td>
<td>278/4215 (6.9%) per subject</td>
</tr>
<tr>
<td>Other*</td>
<td>5/38 (13.2%)</td>
<td>5/52 (9.6%)</td>
<td>Not Reported</td>
</tr>
</tbody>
</table>

This table includes all enrolled HeRO Graft subjects, including the 4 that did not receive the device.

1. Total number of events; II. Subjects with at least one event; III. Percent of subjects with at least one event; IV. Literature reports all deaths and not just device or procedure-related deaths; V. HeRO literature reports all infections including bacteremia or sepsis; VI ‘Other’ serious device and/or procedure-related events included right atrial clot, hypotension with fever, non-sustained ventricular tachycardia, arrhythmia, carotid artery, shunt, hypotension, hypoxia, hypertension, elevated white blood cell count.

In some instances, a direct comparison between the HeRO Graft data and the literature cannot be made because the only literature data available is reported per the overall ESRD population as specific catheter or graft populations. Additionally, some catheter literature data is only appropriate to report per catheter rather than per subject such as procedure related adverse events.

**PROCEDURE ACCESSORIES**

In addition to the Accessory Component Kit, some vascular access surgical instruments may be required.

**Vascular access surgical instruments including, but not limited to, the following:**

- SF micro-puncture set
- Various 0.035" guidewires at least 145cm in length
- Heavy duty scissors
- Heparinsed saline
- 4 x 6 sterile gauze pads
- Various subcutaneous tissue & skin sutures
- Radiographic contrast fluid
- Tissue tunneler set with 6mm & 7mm bullet tips
- Various atraumatic vascular clamps (for the Arterial Graft Component)
- Standard vessel loops
- Syringe & syringe adapter
- Sterile surgical lubricant
- Access needles

**PATIENT SELECTION CONSIDERATIONS**

The following patient considerations should be evaluated prior to initiating the implant procedure:

1. Ensure proper patient selection via vessel mapping:
   a. If vessel mapping indicates that a viable fistula or graft can be placed, consider these options first.
   b. The target artery must have an ID of at least 3 mm to provide adequate arterial inflow to support the graft.
2. Verify the ejection fraction is greater than 20%.
3. Verify the systolic blood pressure is at least 100 mmHg.
4. Obtain screening blood cultures to rule out asymptomatic bacteremia prior to HeRO Graft implant for any patient dialyzing on a catheter; treat patient with antibiotics per culture outcome and ensure infection is resolved prior to HeRO Graft implant procedure.
5. Swab the patient’s nose prior to HeRO Graft implant for potential methicillin resistant staphylococcus aureus; treat accordingly.

Thrombosis is the most common cause of vascular access dysfunction. Missed hemodialysis sessions are more likely to increase the number of thrombosis episodes in AVGs.*

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*Translation notes:
- Some vascular access surgical instruments may be required.
- Thrombosis is the most common cause of vascular access dysfunction. Missed hemodialysis sessions are more likely to increase the number of thrombosis episodes in AVGs.
**Venous Outflow Component**

1. For patients undergoing general anesthesia, consider Trendelenburg position. Additionally, anesthesia personnel should force a positive breath to reduce the potential for air embolus during implant.

2. Caution: Use of the HeRO Graft was clinically studied using the internal jugular vein. Central venous access through any other veins, for example the subclavian vein, has NOT been studied and may increase the risk of adverse events not encountered in the clinical trial. When using the subclavian vein for venous access, consideration should be made to follow these patients with clavicle imaging to monitor the potential of interaction of the clavicle and first rib with the Venous Outflow Component.

3. Caution: Apply antibiotic ointment to the bridging catheter exit site.

4. Caution: Plan for increased bacteremia risk after an ipsilateral HeRO Graft placement or with femoral bridging catheters and treat prophylactically with antibiotics knowing patients are at higher infection risk.

5. Caution: Cover any catheter extensions with antimicrobial incise drape covering to protect the sterile area.

6. Caution: Do not insert the sheath/dilator too far. The tabs must extend well outside the body.

7. Caution: Do not bend introducer sheath or dilator or use them to bypass stenosis.

8. Caution: Apply antibiotic ointment to the bridging catheter exit site.

9. Caution: Suture the tract closed from the existing catheter to HeRO Graft tract.

10. Caution: Cover any catheter extensions with antimicrobial incise drape covering to protect the sterile area.

11. Caution: Plan for increased bacteremia risk after an ipsilateral HeRO Graft placement or with femoral bridging catheters and treat prophylactically with antibiotics knowing patients are at higher infection risk.

12. Caution: Do not advance the tip of the delivery stylet into the right atrium.
15. Confirm proper Venous Outflow Component tip placement in the mid to upper right atrium.
16. Gently pull up while peeling away the 20F sheath. Do not peel the sheath close to the incision site; only peel the sheath as it exits the incision site. Verify that the sheath has been completely removed and that the tip of the Venous Outflow Component is in the correct location via fluoroscopy.
17. Remove the guidewire and close the hemostasis valve on the Y-adapter.
18. Begin withdrawal of the 10F delivery stylet while maintaining Venous Outflow Component position. Prior to complete removal of the delivery stylet from the Luer, clamp the Venous Outflow Component at the incision site.

**NOTE:** Be careful not to overclamp (i.e., do not advance past the locking tab on the clamp handle).

**Caution:** To avoid potential damage to the Venous Outflow Component, use only the atraumatic clamp provided in the Accessory Component Kit.
19. Detach the Y-adapter from the delivery stylet. Open the stopcock and attach the Y-adapter to the silicone Luer on the Venous Outflow Component.
20. Attach a syringe to the stopcock and unclamp the Venous Outflow Component. Aspirate and close the stopcock. Reclamp the Venous Outflow Component and remove the syringe.
21. Attach a syringe with heparinized saline. Open the stopcock, remove the clamp and flush the Venous Outflow Component. Reclamp the Venous Outflow Component at the incision site and close the stopcock.
22. Return the patient to standard supine position.
23. Make the connector site incision at the deltopectoral groove (DPG).
24. Holding the Venous Outflow Component away from the incision sites, use heavy duty scissors to make a straight cut and remove the silicone Luer end. Discard the unused portion.

**Caution:** Avoid displacing the Venous Outflow Component tip during manipulation.
**Caution:** The cut end of the Venous Outflow Component may have sharp edges. Avoid glove contact to prevent puncture.
25. Using a standard Bard® Kelly-Wick tunneler with a 6mm bullet tip, tunnel from the DPG to the venous incision site.
26. Insert the 6mm bullet tip into the end of the Venous Outflow Component, pull through the tunnel to the DPG and remove the bullet tip.

**Caution:** DO NOT bend the Venous Outflow Component beyond a 2.5cm diameter anywhere along its length to prevent kinking.

**NOTE:** Alternatively, a Bard Bi-Directional Tunneler may be used. Consult manufacturer IFUs for proper utilization.

**IMPLANTING THE ARTERIAL GRAFT COMPONENT**
1. Open the Arterial Graft Component using aseptic technique.
2. Make an incision at the selected arterial anastomosis site. Using a standard vessel loop, expose the artery and verify the ID is greater than 3mm in size. Verify patency via Doppler or tactile feel.

**Caution:** Use of the HeRO Graft was clinically studied using the brachial artery. Arterial implantation of the device to other arteries has NOT been studied and may increase the risk of adverse events not encountered in the clinical trial. However, identification of an alternative artery with an ID of 3mm or greater may result in improved blood flow compared to a brachial artery with an ID of less than 3mm.
3. Using a standard Kelly-Wick tunneler with a 7mm bullet tip, follow the previously drawn soft C graft routing path to create a subcutaneous tunnel from the arterial incision site to the connector incision site at the DPG. Graft routing will vary depending on patient-specific anatomy.
4. Remove the 7mm bullet tip from the Kelly-Wick tunneler and reattach the 6mm bullet tip.
5. Attach the graft end of the Arterial Graft Component onto the 6mm bullet tip and secure a tight connection with a suture(s).
6. Gently pull the Arterial Graft Component through the tunnel to the arterial incision site. Use the markings on the Arterial Graft Component to verify it has not twisted.
7. Leave approximately 8cm of the Arterial Graft Component exposed at the DPG incision site to facilitate the connection from the Arterial Graft Component to the Venous Outflow Component.
8. Cut the Arterial Graft Component from the tunneler and use a standard vascular clamp to occlude the Arterial Graft Component at the anastomosis site.

**CONNECTING THE HeRO GRAFT**
1. Place a sterile 4x4 gauze pad between the Venous Outflow Component and the DPG incision site to prevent debris from contaminating the incision.
2. Determine the Venous Outflow Component length required to make the connection to the Arterial Graft Component at the final DPG location. Make a straight cut using heavy duty scissors.

**Caution:** DO NOT test fit the Venous Outflow Component onto the connector as it was designed not to separate once connected.
3. Hold the Venous Outflow Component 2cm from the cut end and advance it over both barbs and up to the connector shoulder.

Caution: The HeRO Graft Venous Outflow Component was designed to engage both barbs of the connector tightly so that the pieces do not separate. If separation is necessary, a new straight cut should be made to the Venous Outflow Component near the connector. Special care should be taken when trimming and removing the excess Venous Outflow Component piece from the connector. Clean the connector of any material or residue. If damage occurs to the connector during separation, a new Arterial Graft Component should be used. Use fluoroscopy to recheck radiopaque tip placement after any adjustment is made.

Caution: DO NOT grasp, peel, or otherwise damage the Arterial Graft Component beading as this may adversely impact the integrity of the graft. It is important during device connection to grasp the silicone sleeve of the Arterial Graft Component and avoid contact with the beading. Ensure the beading is not removed, crushed or damaged.

Caution: If damage to the beading is noted during implant, a new Arterial Graft Component should be used.

Caution: Damaged or crushed beading may lead to flow disruption within the HeRO Graft, and may contribute to early device occlusion and/or repeated occlusion.

4. Verify the Venous Outflow Component is fully advanced onto the connector and flush with the connector shoulder.

5. After the connection is made, verify radiopaque tip placement in the mid to upper right atrium using fluoroscopy.

6. Carefully position the connector in the soft tissue at the DPG. Reposition the Arterial Graft Component from the arterial end to remove excess material.

7. Remove the clamps at the Venous Outflow Component and arterial anastomosis sites to backbleed the entire HeRO Graft.

8. Reclamp the Arterial Graft Component while avoiding the beading.

9. Attach a syringe with heparinized saline to the Arterial Graft Component using a syringe adapter. Remove the clamp and flush the entire HeRO Graft. Verify there is no leakage at the connection sites and reclamp the Arterial Graft Component.

Caution: If leakage is observed, check for proper connection of the Arterial Graft Component to the Venous Outflow Component.

ARTERIAL GRAFT COMPONENT AND ARTERY CONNECTION

1. Cut the Arterial Graft Component to length, avoiding excessive tension or excess material. Verify there are no kinks, twists, or bends in the Arterial Graft Component.

2. Perform the arterial anastomosis using standard surgical techniques.

Caution: Use a small diameter tapered needle with a non-cutting edge to reduce the incidence of suture hole bleeding.

3. Remove the clamp, check the device patency using standard Doppler technique. Verify there is no leakage at the Venous Outflow Component and the Arterial Graft Component connection sites using angiography.

4. Verify thrill and bruit.

5. Evaluate for steal syndrome during the implant procedure with Doppler of the radial and ulnar arteries. If steal syndrome symptoms occur, consider surgical interventions such as:
   • DRIL (distal revascularization-interval ligation) procedure
   • Banding, though this may reduce the flow in the HeRO Graft
   • Proximalization of the inflow

NOTE: Banding may reduce flow in the HeRO Graft.

6. Close all three incision sites.

POST IMPLANT INFORMATION

1. Complete the Implant Notification Fax Form in the Patient Information Pouch and fax the completed form to the patient’s dialysis center.

2. The healthcare provider must place the peel tabs from the label of the implanted HeRO product(s) on the Patient Implant Card and supply the patient with the Patient Implant Card.

3. The healthcare provider is responsible for instructing the patient on proper postoperative care.

4. The healthcare provider shall inform the patient of the residual risks, contra-indications, undesirable side-effects, warnings and measures to be taken in the event of malfunction of the device. This should include information pertaining to the MRI safety information included in this IFU and also on the Patient Implant Card.

VASCULAR ACCESS CANNULATION

Follow KDOQI guidelines for graft assessment, preparation and cannulation.

• The Arterial Graft Component requires 2–4 weeks to incorporate prior to cannulation.
• Swelling must subside enough to allow palpation of the entire Arterial Graft Component.
• Rotation of cannulation sites is needed to avoid pseudoaneurysm formation.
• A light tourniquet may be used for cannulation as the thrill and bruit may be softer than a conventional ePTFE graft due to the elimination of the venous anastomosis.

Post-dialysis, and following needle removal, apply moderate digital pressure at the puncture site until hemostasis is achieved. To decrease the risk of an occlusion, do not use mechanical clamps or straps.

Caution: DO NOT cannulate the HeRO Graft within 8cm (3") of the DPG incision to avoid damage to the beaded section of the Arterial Graft Component.

Caution: DO NOT cannulate the Venous Outflow Component.
Caution: Remove the bridging catheter as soon as possible once the HeRO Graft is ready to be cannulated to decrease the risk of an infection related to the bridging catheter.

Caution: All bridging catheters should be cultured upon explant. In the event catheter tip cultures are positive, treat the patient with appropriate antibiotics to decrease the risk of the HeRO Graft becoming infected.

For additional information refer to the HeRO Graft Care & Cannulation Guide or review it online at www.merit.com/hero.

EXPLANT PROCEDURE
If the patient moves to another form of Renal Replacement Therapy such as receiving a kidney transplant, it is recommended to remove the VOG and ligate the graft.

To Explant the HeRO Graft Venous Outflow Component and Arterial Graft Component Connector or Adapter:

1. Prep patient using aseptic surgical technique. Place the patient into Trendelenburg position to reduce the potential for air embolism during removal.

2. Open the incision at the deltopectoral groove (DPG) and dissect to expose at least 5 cm of the graft, including the connector and FEP beading (for Arterial Graft Component).

3. Carefully dissect the exposed graft and Arterial Graft Component connector or the Adapter to free the incorporated material for ease of revision.

4. For the Arterial Graft Component, ligate the graft approximately 1 cm distal to the FEP beading. NOTE: If the Adapter has been used, grafts that are permitted to be used with the device are not beaded. For the Adapter with an ePTFE graft, ligate the graft approximately 1 cm from the end of the Support Seal (if used) or the Adapter inflow graft end.

5. For the Arterial Graft Component, cut the graft component between the ligation and the FEP beading to separate the Venous Outflow Component.

6. For the Adapter with an ePTFE graft, cut the graft between the ligation and the end of the Support Seal (if used) or the Adapter inflow graft end to separate the Venous Outflow Component.

7. Gently twist to loosen the Venous Outflow Component with attached Arterial Graft Component connector or the Adapter. Using appropriate technique, (i.e., slip tip syringe) apply negative pressure to remove potential intraluminal thrombus.

8. Pull gently using counter pressure applied at the original venous incision site until the Venous Outflow Component with the Arterial Graft Component connector or the Adapter is fully removed and close previous entry site of Venous Outflow Component with purse string suture.

Caution: Upon removing the Venous Outflow Component and Arterial Graft Component connector or the Adapter, continue applying pressure at the original venous incision site to decrease risk of bleeding and air embolism.

9. After removal of the components, close the DPG incision site.

General Caution:
- During removal of the Venous Outflow Component, special care should be used if there is a stent in the vessel. Use imaging (fluoroscopy) for visualization of the Venous Outflow Component and stent interaction to decrease the potential of Venous Outflow Component, stent, or vessel damage.
- Only qualified healthcare providers should explant the device.
- Adhere to universal precautions when explanting the device.

NOTE: The HeRO Graft has been in contact with body fluids and is a potential biohazard. Handle the device using acceptable medical practice and applicable local, state and federal laws and regulations.

EXCHANGE PROCEDURE FOR VENOUS OUTFLOW COMPONENT
If the Venous Outflow Component is not performing as expected, it can be removed or exchanged as it does not incorporate into venous anatomy. Potential reasons the Venous Outflow Component may need to be replaced may include but are not limited to: kinking, incorrect placement, patient injury/fall which dislodges the distal tip placement, infection, etc. Fluoroscopy is required during insertion of a new Venous Outflow Component to avoid vessel damage and ensure proper placement. Due to the complexity and permutations of this procedure, clinical support is recommended. Ligate the graft approximately 1 cm distal to the FEP beading. NOTE: If the Adapter has been used, grafts that are permitted to be used with the device are not beaded. For the Adapter with an ePTFE graft, ligate the graft approximately 1 cm from the end of the Support Seal (if used) or the Adapter inflow graft end.

Caution: Upon removing the Venous Outflow Component and Arterial Graft Component connector or the Adapter, continue applying pressure at the original venous incision site to decrease risk of bleeding and air embolism.

General Cautions:
- During removal of the Venous Outflow Component, special care should be used if there is a stent in the vessel. Use imaging (fluoroscopy) for visualization of the Venous Outflow Component and stent interaction to decrease the potential of Venous Outflow Component, stent, or vessel damage.
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Caution: Upon removing the Venous Outflow Component and Arterial Graft Component connector or the Adapter, continue applying pressure at the original venous incision site to decrease risk of bleeding and air embolism.

General Cautions:
- During removal of the Venous Outflow Component, special care should be used if there is a stent in the vessel. Use imaging (fluoroscopy) for visualization of the Venous Outflow Component and stent interaction to decrease the potential of Venous Outflow Component, stent, or vessel damage.
- Only qualified healthcare providers should explant the device.
- Adhere to universal precautions when explanting the device.

NOTE: The HeRO Graft has been in contact with body fluids and is a potential biohazard. Handle the device using acceptable medical practice and applicable local, state and federal laws and regulations.

Tools Required:
- Venous Outflow Component
- Accessory Component Kit
- *0.035" stiff guidewire at least 150 cm in length

Recommended Accessories:
- Stiffened SF Micropuncture Introducer Set (such as Merit P/N S-MAK501N)
- Heavy duty scissors

1. Prepare the patient according to standard surgical guidelines. Place the patient into Trendelenburg position to reduce the potential for air embolism during exchanges. For patients undergoing general anesthesia, a positive breath can be forced during removal of the dilator from the sheath to prevent air induction.

2. Prepare the SF microintroducer by removing the 0.018" wire-compatible dilator and securely attaching the sheath to the Y-adapter (from the Accessory Component Kit). Flush the sheath with heparinized saline via the Luer port.

3. Palpate to locate the Arterial Graft Component connector or the Adapter. Open the deltopectoral groove (DPG) incision to expose the FEP beading (Arterial Graft Component) and at least 5 cm of the Venous Outflow Component.

4. Clamp the graft with an atraumatic vascular clamp near the FEP graft beading. Inject the graft with heparinized saline to maintain patency.

Caution: Do not clamp the FEP beading as damage to the beading may result. If damage occurs, replacement of the Arterial Graft Component is recommended.

5. Palpate the venous access site to confirm location of the Venous Outflow Component. Open the previous incision and expose the Venous Outflow Component nearest the point it enters/exits the vein.

6. Create a purse string suture at the venous access site and clamp the Venous Outflow Component using the clamp in the Accessory Component Kit nearest the point it enters/exits the vein.

7. Place 4x4 gauze under the connector to prevent debris from contaminating the incision site.

8. Ensure both clamps are secure and cut the Venous Outflow Component with a pair of heavy-duty scissors approximately 3 cm from the Arterial Graft Component connector or the Adapter.

9. Using the heavy-duty scissors, cut the remainder of the Venous Outflow Component from the Arterial Graft Component connector or the Adapter starting at the Arterial Graft Component connector shoulder or the Adapter shoulder and working toward the cut end.

Caution: Cutting through the nitinol braiding of the Venous Outflow Component may be difficult. Do not damage the barbs on the Arterial Graft Component connector or Adapter. If damage occurs, replacement of the Arterial Graft Component or Adapter with a new Arterial Graft Component or Adapter with a new ePTFE graft* is recommended.

*See Tables 1 and 2 in IFU 403225620 for the HeRO Graft Adapter for full details on the ePTFE grafts that have been tested and are permitted for use with the Adapter.

10. Once completed, remove the 4x4 gauze and inspect the wound for any potential debris left behind. Replace the gauze and continue the procedure.
Until it can be removed from the site incision and return the patient to standard supine with heparinized saline. Ensure that the hub is securely seated in the Venous Outflow Component and remove the clamp.

Aspirate blood from the device. Under fluoroscopic guidance, advance the guidewire to the desired position in the inferior vena cava.

Maintaining guide wire position, gently remove the existing Venous Outflow Component over the wire. The purge string suture can help control bleeding at the venous access site.

Load the 20F peel away sheath onto the guidewire and use fluoroscopy to advance.

Flush the Venous Outflow Component with heparinized saline.

Apply sterile surgical lubricant to the 10F delivery stylet and advance through the silicone Luer end of the Venous Outflow Component.

Remove the Y-adapter from the 5F microcatheter assembly and attach to the Luer End of the delivery stylet placed within the new Venous Outflow Component.

Attach the stopcock to the Y-adapter and ensure the valve on the stopcock is in the open position and flush with heparinized saline, then close the valve.

To ease insertion into the sheath, apply sterile surgical lubricant to the exterior surface of the Venous Outflow Component.

While stabilizing the guidewire and 20F sheath, begin removing the dilator from the sheath. As soon as the dilator tip has exited the sheath, immediately insert the hemostatic plug by grasping the plug between the thumb and index finger. Firmly insert the hemostatic plug into the sheath alongside the guidewire. Ensure both plug seal rings are fully seated within the sheath. Fully remove the dilator over the guidewire. Avoid pinching or clamping the sheath.

Insert the Venous Outflow Component and delivery stylet assembly over the guidewire. Remove the hemostasis plug and quickly advance the Venous Outflow Component into the 20F sheath.

Under fluoroscopic guidance, advance the Venous Outflow Component to the superior vena cava. A twisting or rotational motion may be used to ease insertion. Holding the delivery stylet fixed, continue to advance the Venous Outflow Component to the mid to upper right atrium.

If resistance is felt, determine the cause before continuing to advance the Venous Outflow Component. Keep the sheath straight to prevent it from kinking. If the sheath is bent, remove it and replace it with a new 20F sheath.

Confirm proper Venous Outflow Component tip placement in the mid to upper right atrium.

Gently pull up while peeling away the 20F sheath. Do not peel the sheath close to the incision site; only peel the sheath as it exits the incision site. Verify that the sheath has been completely removed and that the tip of the Venous Outflow Component is in the correct location via fluoroscopy.

Remove the guidewire and close the hemostasis valve on the Y-adapter.

Begin withdrawal of the 10F delivery stylet while maintaining Venous Outflow Component position. Prior to complete removal of the delivery stylet from the Luer, clamp the Venous Outflow Component at the incision site with the synthetic plug clamp included in the Accessory Component Kit.

NOTE: Be careful not to overlap (i.e., do not advance past the locking tab on the clamp handle)

Detach the Y-adapter from the delivery stylet. Open the stopcock and attach the Y-adapter to the silicone Luer on the Venous Outflow Component.

Attach a syringe to the stopcock and unclamp the Venous Outflow Component. Aspirate and close the stopcock. Reclamp the Venous Outflow Component and remove the syringe.

Attach a syringe with heparinized saline. Open the stopcock, remove the clamp and flush the Venous Outflow Component. Reclamp the Venous Outflow Component at the incision site and close the stopcock.

Holding the Venous Outflow Component away from the incision site, use heavy duty scissors to make a straight cut and remove the silicone Luer and Y-adapter assembly. Discard unused portion. Tunnel through the existing tract to the connection site.

Remove the clamp from the Venous Outflow Component and flush with heparinized saline. Reclamp the Venous Outflow Component at the venous incision site.

Unclamp the graft, confirm patency and reclamp.

For the Arterial Graft Component, grasp the silicone sleeve on the connector in one hand. NOTE: If the Adapter has been used, it does not have a silicone sleeve. It may be grasped in one hand on the closed clamshells. In the other hand, grasp the Venous Outflow Component 2cm back from the connector and place it over both barbs and up to the connector shoulder of the Arterial Graft Component or Adapter shoulder. Verify the Arterial Graft Component or the Adapter with an ePTFE graft and Venous Outflow Component are fully connected.

Caution: Do not peel or otherwise damage the graft being as this may adversely impact the integrity of the graft. If damage occurs, replacement of the Arterial Graft Component is recommended.

NOTE: If the Adapter has been used, grafts that are permitted to be used with the device are not beaded.

NOTE: Be careful not to overlap (i.e., do not advance past the locking tab on the clamp handle).

Radioropaque tip placement in the mid to upper right atrium using fluoroscopy.

Gently tug the connected device into the Arterial Graft Component or the Adapter site incision and return the patient to standard supine position.

Remove all clamps and confirm device patency before closing incisions.

The HeR0 Graft has been in contact with body fluids and is a potential biohazard. Handle the device using acceptable medical practice and applicable local, state and federal regulations.

If the device was removed due to performance issues, return the explanted portion of the device to Merit Medical Systems by contacting Customer Service at 1-800-356-3748.

REVISE THE HERO GRAFT ARTERIAL GRAFT COMPONENT OR THE HERO ADAPTER WITH AN ePTFE GRAFT:

If the HeR0 Graft is no longer able to provide adequate dialysis it can be revised or replaced due to potential reasons such as but not limited to; adequacy of dialysis (Kt/V), stenosis, increased pressures during dialysis, excessive bleeding at graft cannulation sites, swelling of the limb, edema around graft site, etc.
2. Create a subcutaneous tunnel from new inflow incision site to the new outflow incision site circumventing the existing graft. Graft routing may vary depending on patient-specific anatomy and the placement of the existing graft.

3. Using standard graft tunneling techniques, gently pull the jump graft through the new tunnel. Utilize markings on the graft to verify it has not twisted.

**NOTE:** If replacing the entire Arterial Graft Component, connect the Venous Outflow Component to the connector of the Arterial Graft Component.

4. Use a standard vascular clamp to occlude the existing graft near the new inflow anastomosis site.

5. Perform a standard graft-to-graft anastomosis.

6. Remove the clamp, bleed the jump graft segment to remove air, and then reclamp the jump graft segment next to the new outflow anastomosis site.

7. Cut the graft to length, avoiding excessive tension or redundant graft material, and perform the outflow anastomosis of the jump graft to the existing graft using standard technique.

8. Remove the clamp and check the device patency, utilizing standard Doppler technique.

9. Close both incisions.

**NOTE:** The HeRO Graft has been in contact with body fluids and is a potential biohazard. Handle the device using acceptable medical practice and applicable local, state and federal laws and regulations.

If the device was removed due to performance issues, return the explanted portion of the device to Merit Medical Systems by contacting Customer Service at 1-800-356-3748.

If the HeRO Graft is abandoned for any reason, we recommend removal of the Venous Outflow Component. The ePTFE graft portion of the Arterial Graft Component or the Adapter would typically not be removed due to maturation/ incorporation of surrounding tissue into the ePTFE graft material. It can be ligated and left in place similar to conventional AV grafts.

**PERCUTANEOUS THROMBECTOMY**

Similar to conventional arteriovenous grafts or fistulas, the HeRO Graft System will require intervention such as thrombectomy to maintain graft patency. The HeRO Graft System is up to 130 cm in length, and therefore requires a longer thrombectomy device to traverse the entire length of the device.

**Caution:** Do not use mechanical/rotational thrombectomy devices (e.g., Arrow-Trerotola PTD®) in the Venous Outflow Component and/or connector as internal damage may occur to these components.

Use of fluoroscopy is recommended for all HeRO Graft System interventions. The following outlines the general procedural steps involved with a percutaneous thrombectomy procedure:

**PERCUTANEOUS THROMBECTOMY (DECLOTTING) THE HERO GRAFT SYSTEM**

1. Introduce a 7 Fr short vascular sheath near the arterial anastomosis.

2. Inflate a soft, compliant embolectomy balloon at the distal radiopaque marker band of the Venous Outflow Component. To avoid dislodging the Venous Outflow Component, the balloon should not be advanced distally beyond the radiopaque marker band.

3. Perform a balloon pull-back to the level of the connector.

4. At the level of the connector, aspirate while deflating the balloon by approximately 10%. Failure to deflate the balloon may result in balloon perforation as the catheter passes through the connector.

5. Reinflate the balloon once the balloon has passed through the connector and resides within the arterial graft.

6. Extract clot at the introducer site.

7. Declot the full length of HeRO Graft prior to removing the arterial plug to decrease risk of pulmonary embolism.
ARTERIAL PLUG REMOVAL

1. Choose a Fogarty embolectomy balloon sized for the artery (3-4mm) and insert past the arterial plug.

2. Inflate the balloon, “pop” the arterial plug, and pull the balloon back to the introducer site.

3. Extract the arterial plug, then confirm flow and patency throughout the device. Ultrasound may be used to assess flow.

4. Reconfirm placement of the connector and Venous Outflow Component tip via fluoroscopy.

5. Proceed with correcting any lesions in the graft as you routinely would.

MRI Safety Information
Non-clinical testing has demonstrated that the HeRO Graft System is MR Conditional. A patient with this device can be safely scanned in an MR system meeting the following conditions:

- Static magnetic field of 1.5 and 3.0 Tesla only
- Maximum spatial gradient magnetic field of 4,000 gauss/cm (40 T/m) or less
- Maximum MR system reported, whole body averaged specific absorption rate (SAR) of 2 W/kg (Normal Operating Mode)

Under the scan conditions defined above, the HeRO Graft System is expected to produce a maximum temperature rise of 4.8°C after 15 minutes of continuous scanning.

In non-clinical testing, the image artifact caused by the device extends approximately 10mm from the HeRO Graft System when imaged with a gradient echo pulse sequence and a 3 Tesla MRI system. The artifact does obscure the device lumen.

WARRANTY DISCLAIMER

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In the event that such a disclaimer is found invalid or unenforceable for any reason: (i) any action for breach of warranty must be commenced within one year after any such claim or cause of action accrued and (ii) the remedy for such breach is limited to the replacement of the product. Prices, specifications and availability are subject to change without notice.

TECHNICAL SUPPORT
To obtain additional information on the HeRO Graft, including questions on infection control procedures, contact the customer service department at:

Merit Medical Systems, Inc.
1600 West Merit Parkway
South Jordan, Utah 84095 U.S.A.
1-801-253-1600
U.S.A. Customer Service 1-800-356-3748
www.merit.com/hero


A bibliography of HeRO Graft publications and presentations is available at www.merit.com/hero.