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- 1 Claim, 8 Drawing Sheets**

A perspective view of a foldable frame assembly. The assembly includes two elongated members, 102 and 104, which are connected at their ends by hinges or joints labeled 106 and 108. The members 102 and 104 are shown in a folded position, forming a V-shape. The joint 102 is located near the bottom left, and the joint 104 is located near the top right. The members 102 and 104 are connected to a central support structure, which is labeled 110. The support structure 110 is a rectangular frame made of four members, with one member labeled 114. The entire assembly is shown in a perspective view.

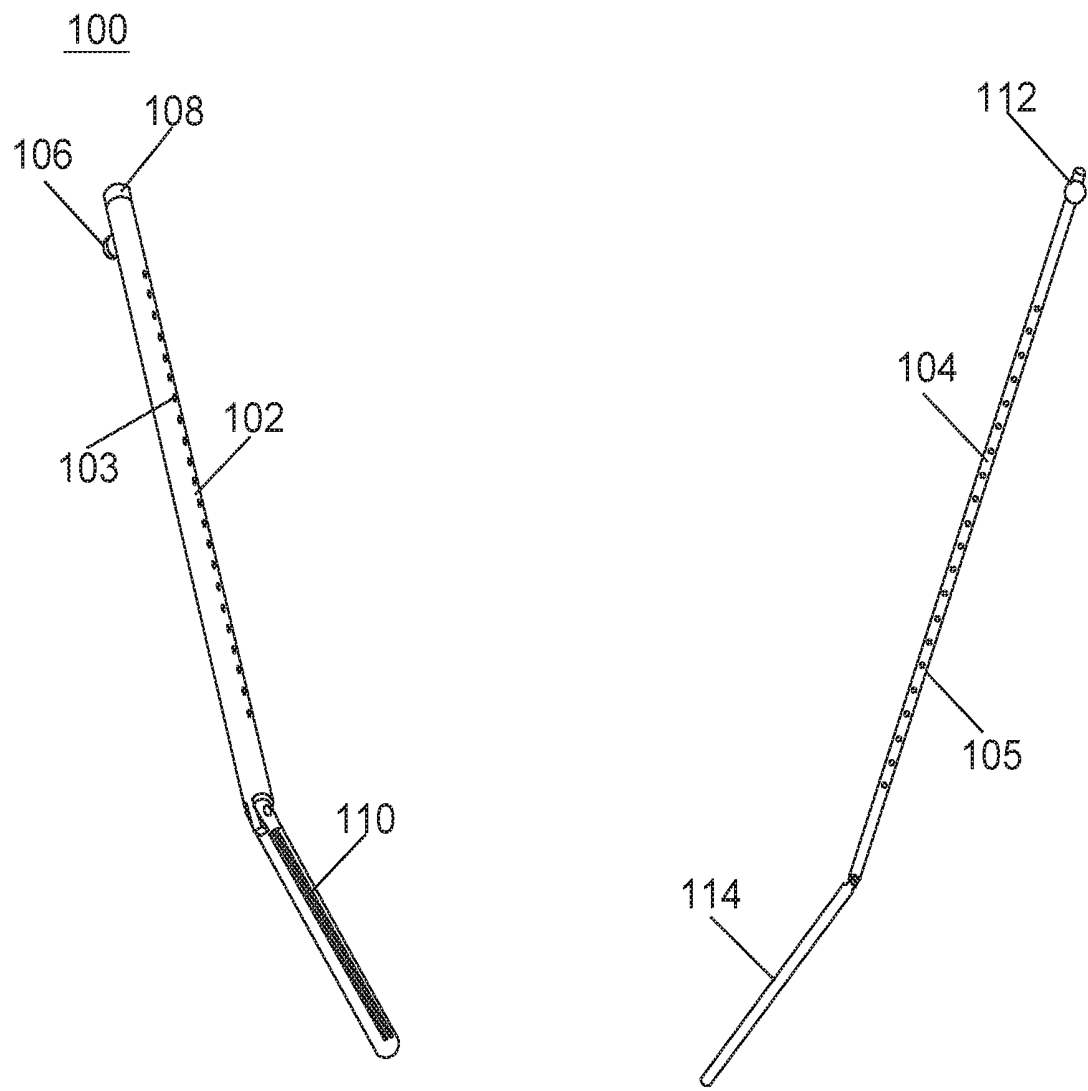


FIG.1

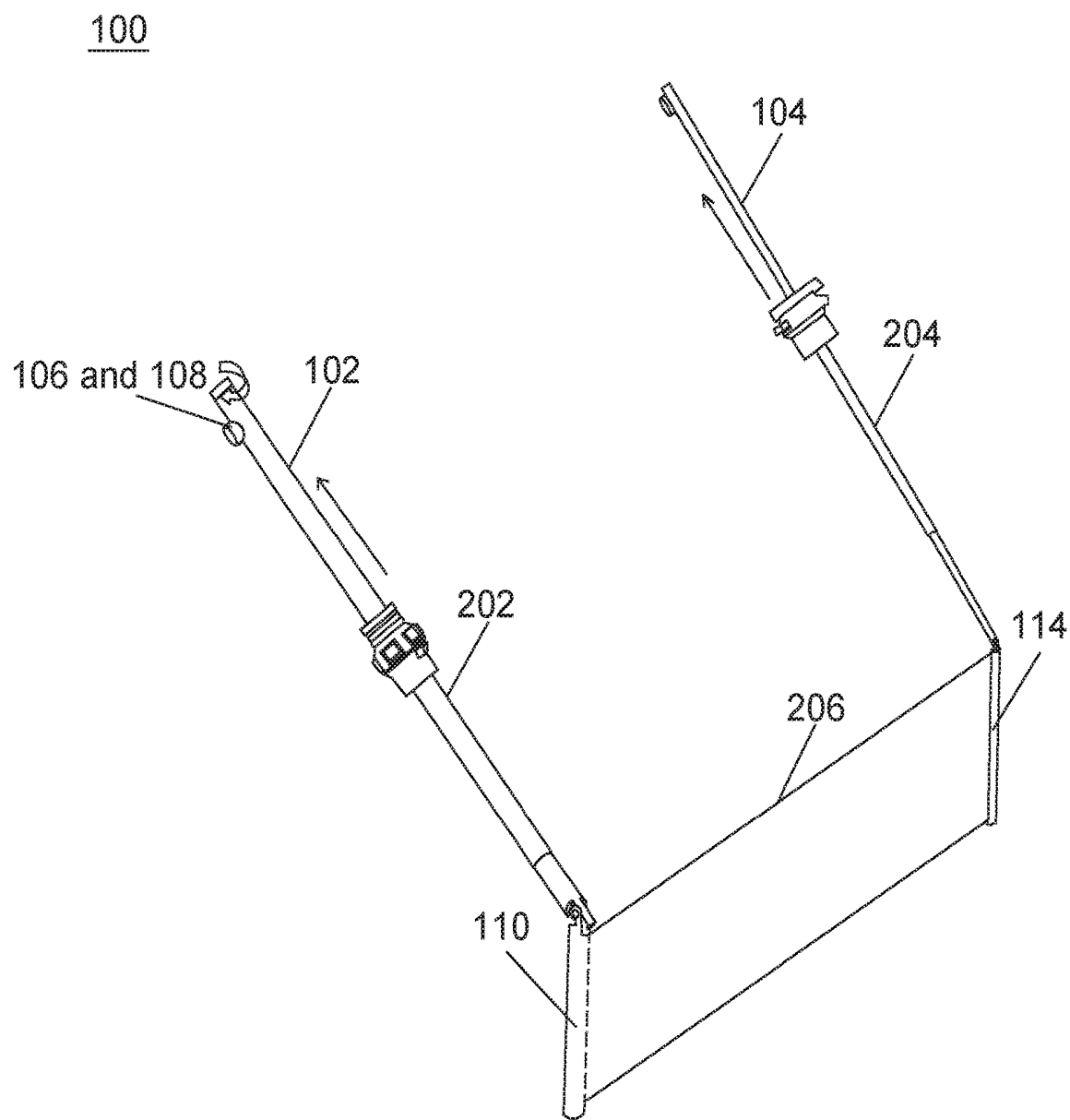


FIG.2

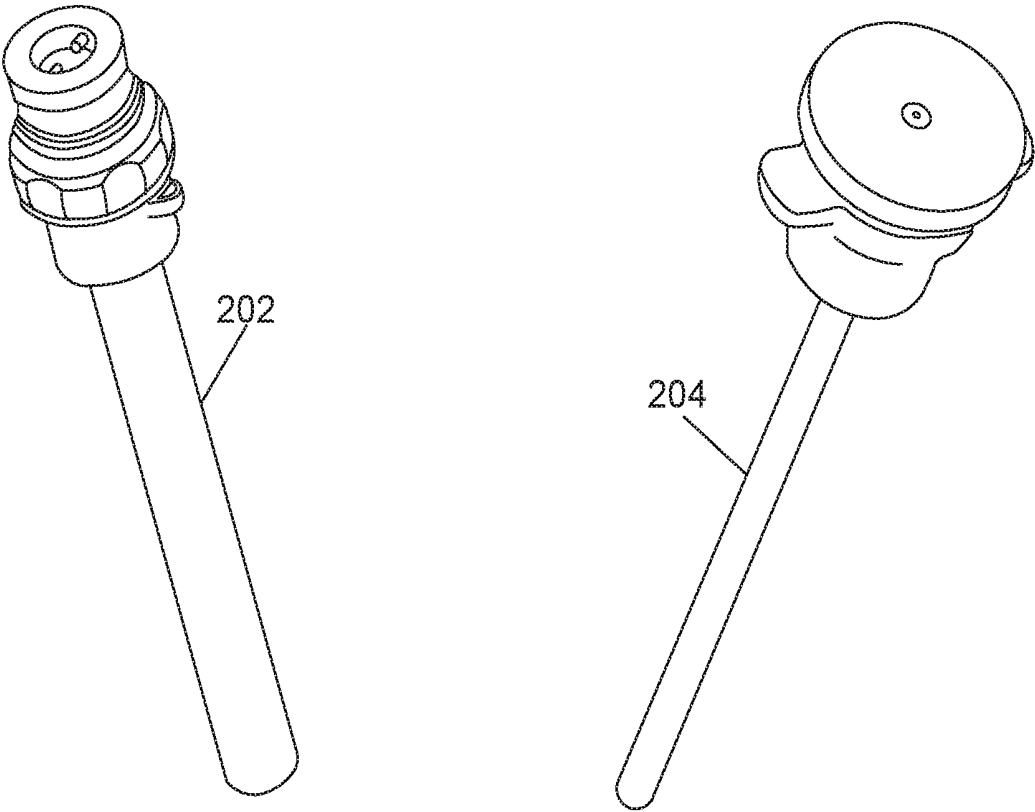


FIG.3

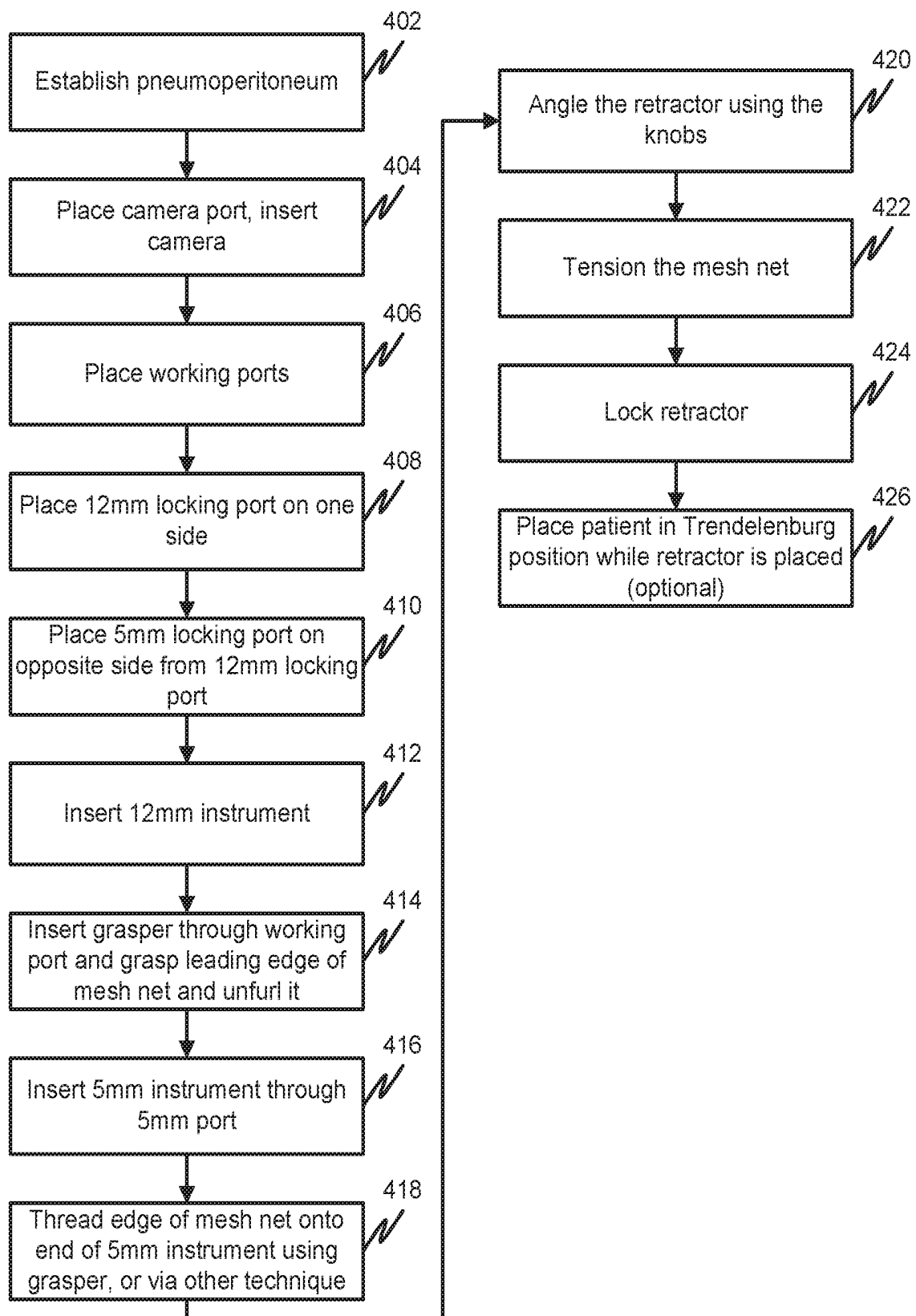


FIG. 4

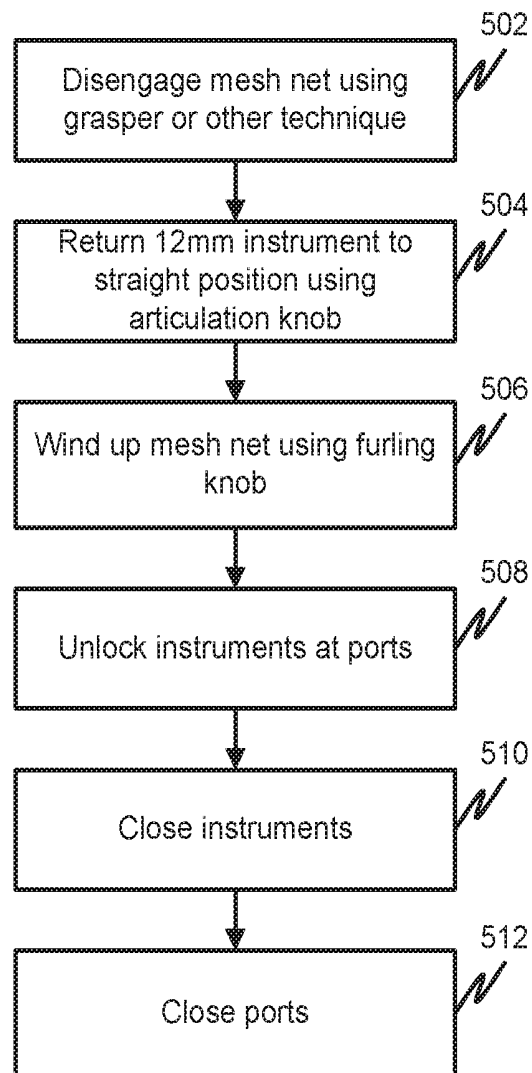


FIG. 5

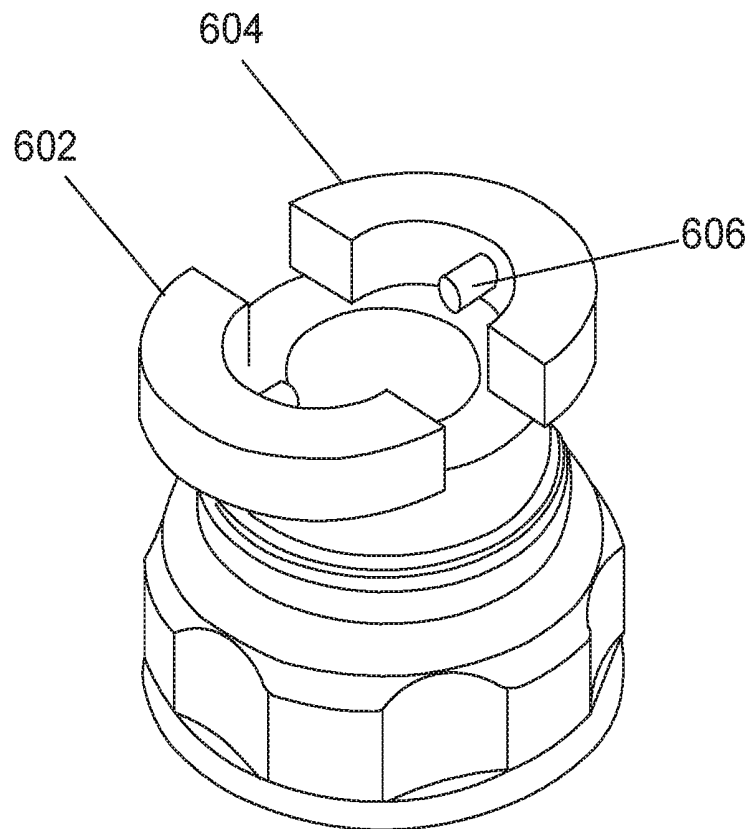


FIG. 6

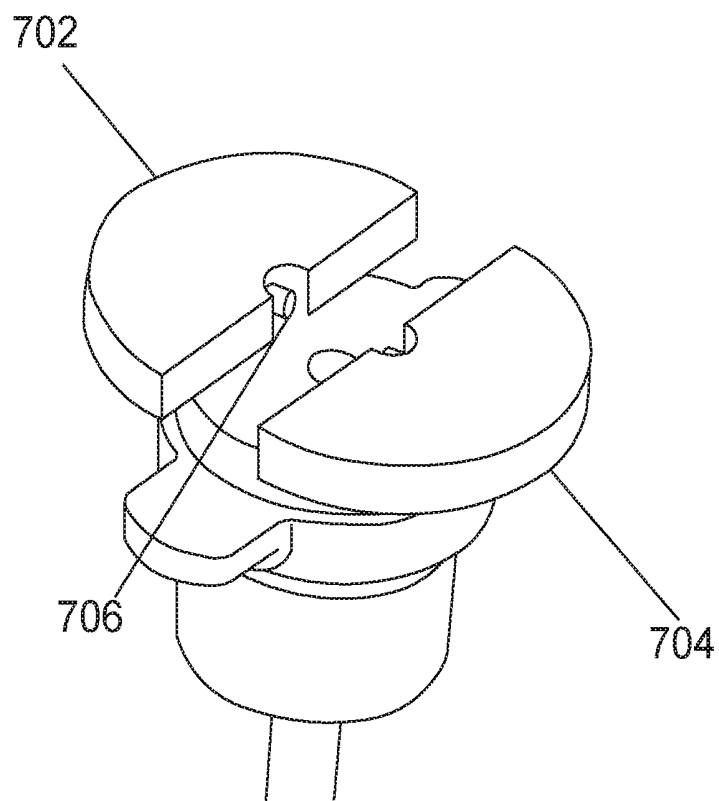


FIG. 7

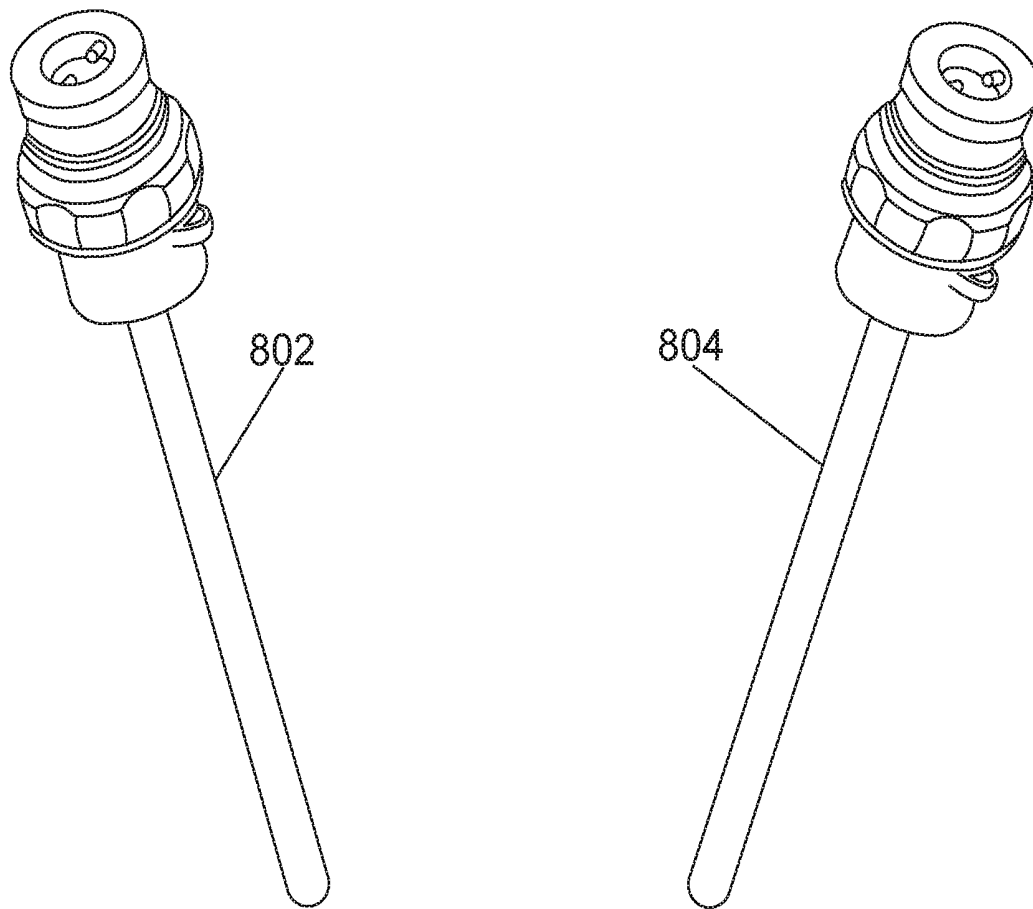


FIG. 8

RETRACTION SYSTEM AND METHOD

RELATED APPLICATIONS

This application claims the benefit of U.S. Provisional Application No. 62/529,670, entitled "Retraction System and Method," and filed on Jul. 7, 2017, which is incorporated herein by reference in its entirety.

TECHNICAL FIELD

Some implementations relate generally to surgical instruments, and more particularly, to a retraction system and method for laparoscopic and/or robot-assisted pelvic surgery and other minimally invasive surgeries.

BACKGROUND

Currently, laparoscopic and/or robot-assisted pelvic surgeries may often require steep Trendelenburg positioning in which a patient being operated upon is placed in a head down position at an angle of about 45 degrees for the duration of the procedure. Such positioning may be necessary to move viscera out of the pelvis so as to provide adequate visualization and exposure of the operative field.

Trendelenburg positioning may suffer some one or more limitations or disadvantages, such as making ventilation of the patient more difficult for the anesthesia staff. Also, patients may need to be padded and securely fastened to the table adding time and therefore cost to the procedure. Further, Trendelenburg positioning has occasionally resulted in complications such as cerebral edema, neurologic complications, lower extremity ischemia, among other adverse events.

Accordingly, a need may exist for a system and method of viscera retraction that involves limited or no Trendelenburg positioning.

Some implementations were conceived in light of the above mentioned needs and limitations, among other things.

SUMMARY

Some implementations can include a retraction system that can reduce use of Trendelenburg positioning to a few minutes and may eliminate the use of Trendelenburg positioning altogether.

Some implementations can include a laparoscopic retraction system that provides broad based retraction similar to that achieved by fixed retractors routinely used in open surgery. The laparoscopic retraction system can hold viscera out of the pelvis so that laparoscopic or robot-assisted pelvic operations can be performed with little or no Trendelenburg positioning required. Some implementations can include a first instrument and a corresponding first locking trocar and a second instrument and a corresponding second locking trocar.

The first (or "male") instrument can include a first device having a mesh net rolled up within the device. The first device is capable of unfurling the mesh net and winding the net back up into the first device. The unfurling and winding up can be controlled by a net control knob located on the external end of the first instrument (i.e. outside the patient's body) and mechanically or electrically coupled to the net winding mechanism located toward the end of the instrument which unfurls and winds up the mesh net. The first locking trocar can be a trocar selected to provide a port of about 5-7 mm, 12 mm or other suitable dimension. The first

instrument can also include an articulation control knob to control articulation of the end of the first instrument inside the patient's body when the first instrument is in use during a procedure. The articulation control knob and the net control knob can include separate control knobs. Both articulation control knobs are disposed on respective portions of the first or second instruments that are external to the patient when the instruments are in use during a procedure.

The second (or "female") instrument can include a second device that is capable of articulating and engaging an edge of the mesh net being unfurled from the first device. The articulation can be controlled by an articulation control knob on the second instrument, where the articulation control knob of the second instrument is disposed on a portion of the second instrument that is external to the patient when the instrument is in use during a procedure. The second device can be used to engage the mesh net and unfurl the mesh net by pulling the mesh net so that the mesh net unwinds from the first device and extends from side to side across the peritoneum. The two instruments can then be positioned and locked into place by the respective locking trocars in order to cause the mesh net to retract and hold the viscera out of the pelvis during a procedure without further attention from the surgical assistant. The second trocar can be a trocar selected to provide a port of about 5 mm.

BRIEF DESCRIPTION OF THE DRAWINGS

FIG. 1 is a diagram of example first ("male") and second ("female") instruments of a retraction system in accordance with some implementations.

FIG. 2 is a diagram of an example retraction system with the mesh net deployed in accordance with some implementations.

FIG. 3 is a diagram of example locking trocars in accordance with some implementations.

FIG. 4 is a flow chart of a method for retraction in accordance with some implementations.

FIG. 5 is a flow chart of a method for retraction in accordance with some implementations.

FIG. 6 is a diagram of an external end of an example locking trocar for the "male" instrument in accordance with some implementations.

FIG. 7 is a diagram of an external end of an example locking trocar for the "female" instrument in accordance with some implementations.

FIG. 8 is a diagram of example locking trocars in accordance with some implementations.

DETAILED DESCRIPTION

FIG. 1 is a diagram of an example first instrument **102** and second instrument **104** of a retraction system **100** in accordance with some implementations. The first instrument **102** (e.g., instrument placed through a 5-7 mm port or a 12 mm port or port of other suitable dimensions) includes one or more holes **103** in the shaft of the instrument, an articulation control knob **106**, a net control knob **108**, and an articulated end **110** that can move in response to control movements of the articulation knob **106** and which holds a wound up retraction mesh net **206** shown in FIG. 2. The second instrument **104** includes one or more holes **105** in the shaft of the instrument, an articulation control knob **112** and an articulated end **114**.

In operation, two additional ports are placed superior to the "working" ports. The two additional ports can include a first port (e.g., a port for the 5 mm-7 mm or 12 mm "male"

instrument that deploys the mesh net) and a second port (e.g., a port for the “female” instrument that accepts and engages the mesh net and locks it into place) formed by respective locking trocars, for example. The first instrument **102** containing the rolled up retractor mesh net (or other suitable retractor material) is placed into the first port provided by the first trocar and the mesh net is unrolled from it. The mesh net is engaged (or captured) by an articulated end **114** of the second instrument **104** that has been placed through the second port **204**. The net is then tensioned by rolling it up using the furling knob **108** on the first instrument **102** and can be articulated to precisely retract the viscera superiorly and out of the operative field. A brief time (e.g., 5 minutes) of Trendelenburg positioning time may be required to get the retraction system in place and positioned. Once satisfactory retraction is achieved, the trocars (**202** and **204**) can lock the two instruments (**102**, **104**) in place via one or more holes on the instruments (**103**, **105**) and may not require further attention by the assistant. The patient can be returned to level positioning and the operation can proceed as usual. A diagram of a deployed retraction system in accordance with some implementations is shown in FIG. 2.

FIG. 2 is a diagram of an example retraction system **100** with the mesh net **206** deployed in accordance with some implementations. In particular, the first instrument **102** is placed through a first trocar **202** and the second instrument **104** is placed through a second trocar **204**. The retractor shown in FIG. 2 is in a locked state.

FIG. 3 is a diagram of example locking trocars (**202**, **204**) in accordance with some implementations. The locking trocars (**202**, **204**) shown in FIG. 3 are shown in a locked state. FIGS. 6 and 7 show the locking trocars (**202**, **204**) in an unlocked state. The locking trocars as disclosed herein (e.g., **202**, **204**) include a hollow tube that enters the body of the patient. Each locking trocar has an exterior opening including two interlocking pieces (e.g., **602/604**, and **702/704**) that are constructed and configured to pull apart (to an unlocked state) and push back together (to a locked state). One or both of these pieces can have one or more pegs (e.g., **606** or **706**) that can fit into one of the holes (e.g., **103** and **105**, in FIG. 1) in the retractor instruments to hold the corresponding retractor instrument in place (“peg-in-hole” structure and technique). Once a port is locked, the retractor instrument in that port should be at least partially immobile relative to longitudinal movement within the locking trocar. An instrument locked in place in the locking trocar, though partially or fully immobile with respect to longitudinal movement within the locking trocar, may still be able to make other movements such as articulating, and extending or retracting the mesh net, etc.

FIG. 4 is a flow chart of a method for retraction in accordance with some implementations. The method begins at **402**, where pneumoperitoneum is established (e.g., with Veress needle or Hassan technique). The method continues to **404**.

At **404**, a camera port is placed and a camera is inserted into the abdomen via the camera port. The method continues to **406**.

At **406**, working ports are placed under direct camera vision. The method continues to **408**.

At **408**, a first “locking” port (e.g., a 5 mm-7 mm or 12 mm port) is placed on one side. The method continues to **410**.

At **410**, a second “locking” port (e.g., 5 mm-7 mm) is placed on the opposite side from the first port. The method continues to **412**.

At **412**, a “male” retractor (e.g., the one that houses the mesh or net roll) is brought in through the first port. The mesh or net can be made of plastic or surgical mesh (e.g., silicone, Prolene™, etc.). The method continues to **414**.

At **414**, a grasper is brought in through one of the working ports and is used to grasp the leading edge of the mesh net and unfurl the mesh net. The method continues to **416**.

At **416**, the “female” retractor is brought in through the second port. The method continues to **418**.

At **418**, using the grasper, the leading edge of the mesh net is threaded into a groove at the end of the “female” retractor. The method continues to **420**.

At **420**, the newly assembled retractor is angled by turning the articulator knob at the top of the instrument (an articulation control knob is present on the exterior end of both “male”/“female” instruments). The method continues to **422**.

At **422**, the retractor is tensioned by tightening the mesh net by twisting the net control knob on top of the “male” piece (rolling up excess mesh net). The method continues to **424**.

At **424**, once the retraction is optimal, the retractor is locked into place with the lock mechanism (e.g., a peg-in-hole structure and technique described above with respect to FIGS. 3, 6, and 7) in the locking trocars. The method continues to **426**.

At **426**, if retraction cannot be easily attained with the patient flat, the patient optionally can be placed briefly in Trendelenburg while the retractor is placed. The patient will then return flat for the remainder of the case. It will be appreciated that **426** can be performed at any point during the procedure.

FIG. 5 is a flow chart of a method for removing retraction in accordance with some implementations. The method begins at **502**, where, at the end of the operation, a grasper brought in through a working port disengages the mesh net from the “female” (e.g., 5 mm port) instrument. The method continues to **504**.

At **504**, the “male” instrument is returned to the straight position by turning the articulator knob. The method continues to **506**.

At **506**, the mesh net is rolled back up by turning the net control knob until the mesh net is back to its original, wound position. The method continues to **508**.

At **508**, the instrument is unlocked at the ports. The method continues to **510**.

At **510**, the instrument is removed. The method continues to **512**.

At **512**, ports are closed per surgeon choice.

The second instrument can engage or capture the retractor mesh net using various structures and techniques. For example, the mesh net can be manipulated with a laparoscopic grasper to bring it into position to be engaged by the second instrument.

Some implementations can significantly reduce or eliminate Trendelenburg positioning time, and thus help reduce or eliminate the disadvantages of Trendelenburg positioning. This could increase patient safety and can help reduce the costs and time required to prepare a patient for Trendelenburg positioning.

Moreover, by reducing or eliminating Trendelenburg positioning, some implementations can help increase the laparoscopic/robot-assisted candidate population. For example, obese patients and those with pulmonary problems could undergo minimally invasive procedures (e.g., laparoscopic or robot-assisted) more safely.

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Currently, retractors may be hand held and thus require an assistant to operate them. Some implementations described herein can be fixed or locked into place, thus reducing or eliminating a need for an assistant to hold the retraction system. Also, the position of one or both instruments of the retraction system described herein can be changed during a procedure when operative conditions change.

It will be appreciated that any dimensions mentioned herein are for purposes of illustrating features and operational aspects of the disclosed subject matter and are not intended to be limiting. Other dimensions could be used.

It will also be appreciated that pelvic surgery (e.g., radical prostatectomy) is described herein as an example application of the retraction system and method. Some implementations could be applicable to other types of surgery.

An implementation of the retraction system and/or method described herein could be used for other procedures including, but not limited to, radical prostatectomy, radical cystectomy, hysterectomy, sacrocolpopexy, low anterior colon resection, and selected herniorrhaphies. Some implementations could be configured for use in various types of surgery including, but not limited to, laparoscopic and/or robot-assisted urological surgery, gynecological surgery, and colorectal surgeries.

It is, therefore, apparent that there is provided, in accordance with the various embodiments disclosed herein, a retraction system and method.

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While the disclosed subject matter has been described in conjunction with a number of embodiments, it is evident that many alternatives, modifications and variations would be, or are, apparent to those of ordinary skill in the applicable arts. Accordingly, Applicants intend to embrace all such alternatives, modifications, equivalents and variations that are within the spirit and scope of the disclosed subject matter.

What is claimed is:

1. A retraction system comprising:

- a first instrument including a shaft having one or more locking holes, a first instrument position locking mechanism configured to engage one or more of the locking holes, an articulation control knob to control articulation of an articulated end of the first instrument, a net control knob to control the deployment and retrieval of a net that is configured to be stored within the first instrument and deployed and retrieved in response to control input from the net control knob; and
- a second instrument including one or more locking holes in a shaft of the second instrument, a second instrument position locking mechanism configured to engage one or more of the locking holes, an articulation control knob to control articulation of an articulated end of the second instrument, wherein the articulated end of the second instrument is configured to engage an end of the net and to removably attach to the end of the net.

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专利名称(译)	缩回系统及方法		
公开(公告)号	US10595843	公开(公告)日	2020-03-24
申请号	US16/027462	申请日	2018-07-05
发明人	PETTUS, IV, JOSEPH ATKINS PETTUS, TRISTAN REILLY		
IPC分类号	A61B1/32 A61B17/02 A61B17/34 A61B17/00 A61B1/313		
CPC分类号	A61B17/0218 A61B17/3423 A61B2017/00367 A61B1/3132 A61B2017/00477 A61B2017/347 A61B2017/0225		
代理人(译)	Aycok通知, II, STEPHEN W.		
优先权	62/529670 2017-07-07 US		
其他公开文献	US20190133566A1		
外部链接	Espacenet		

摘要(译)

一些实施方式可以包括收缩系统，该收缩系统为微创手术（例如，腹腔镜或机器人辅助）提供广泛的收缩，该收缩系统类似于在开放手术中经常使用的固定收缩器所实现的收缩。内缩系统可将内脏从骨盆中移出，例如。一些实施方式可以包括第一器械，第一锁定套管针，第二器械和第二锁定套管针。第一仪器可包括具有网状网的铰接的第一装置。第一设备能够解开网状网并将网缠绕回到第一设备中。第二仪器可以包括第二装置，该第二装置铰接并接合网状网的边缘。第二装置可以接合网状网并通过拉动网状网来帮助展开网状网，使得网状网从第一装置解开并且可以用于缩回内脏。

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