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(54) **SURGICAL TOOLS FOR LASER MARKING
AND LASER CUTTING**

(75) Inventors: **Matthew Reagan Williams**, Walnut
Creek, CA (US); **Gregory William
Dachs, II**, Sunnyvale, CA (US); **David
Shafer**, Menlo Park, CA (US)

(73) Assignee: **Intuitive Surgical Operations, Inc.**,
Sunnyvale, CA (US)

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See application file for complete search history.

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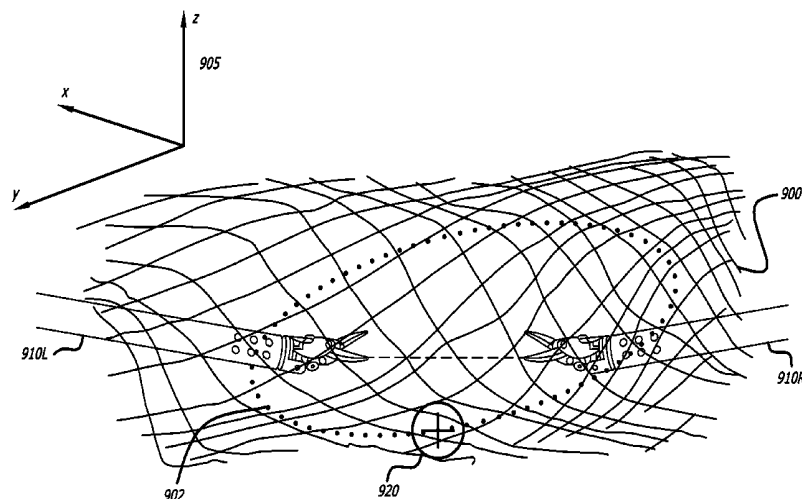
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Primary Examiner — Lynsey C Eiseman

(57) **ABSTRACT**

In one embodiment of the invention, a robotic surgical system includes a combined laser imaging robotic surgical tool, a control console, and a laser generator/controller. The tool is mounted to a first robotic arm of a patient side cart. The tool has a wristed joint and an end effector coupled together. The end effector has a laser-emitting device to direct a laser beam onto tissue in a surgical site and an image-capturing device to capture images of the tissue in the surgical site. The control console, in communication with the tool, receives the captured images of tissue in the surgical site and displays the captured images on a display device to a user. The laser generator/controller is coupled to the tool and the control console to control the emission of the laser beam onto tissue of the surgical site.

9 Claims, 18 Drawing Sheets



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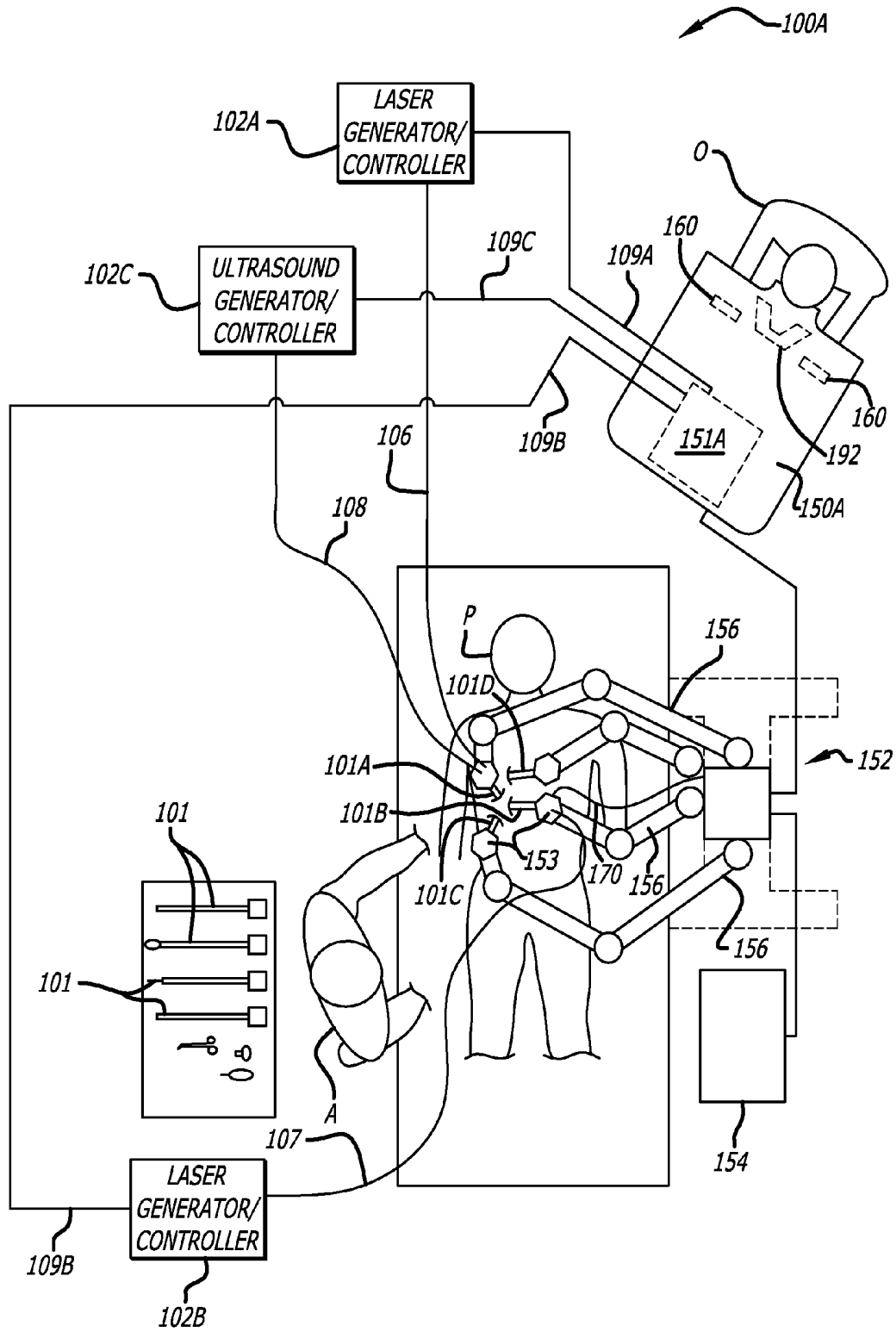


FIG. 1A

FIG. 1B

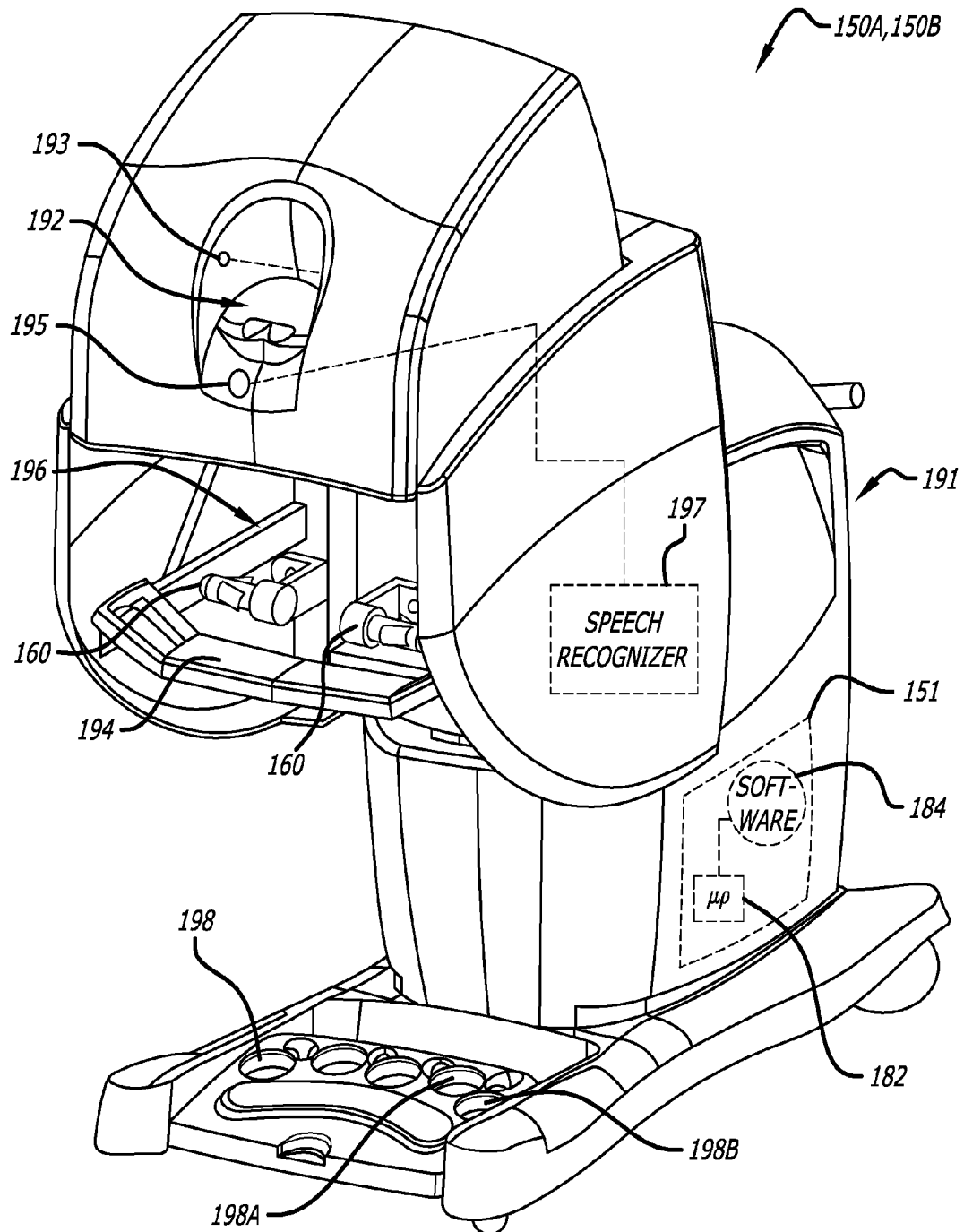
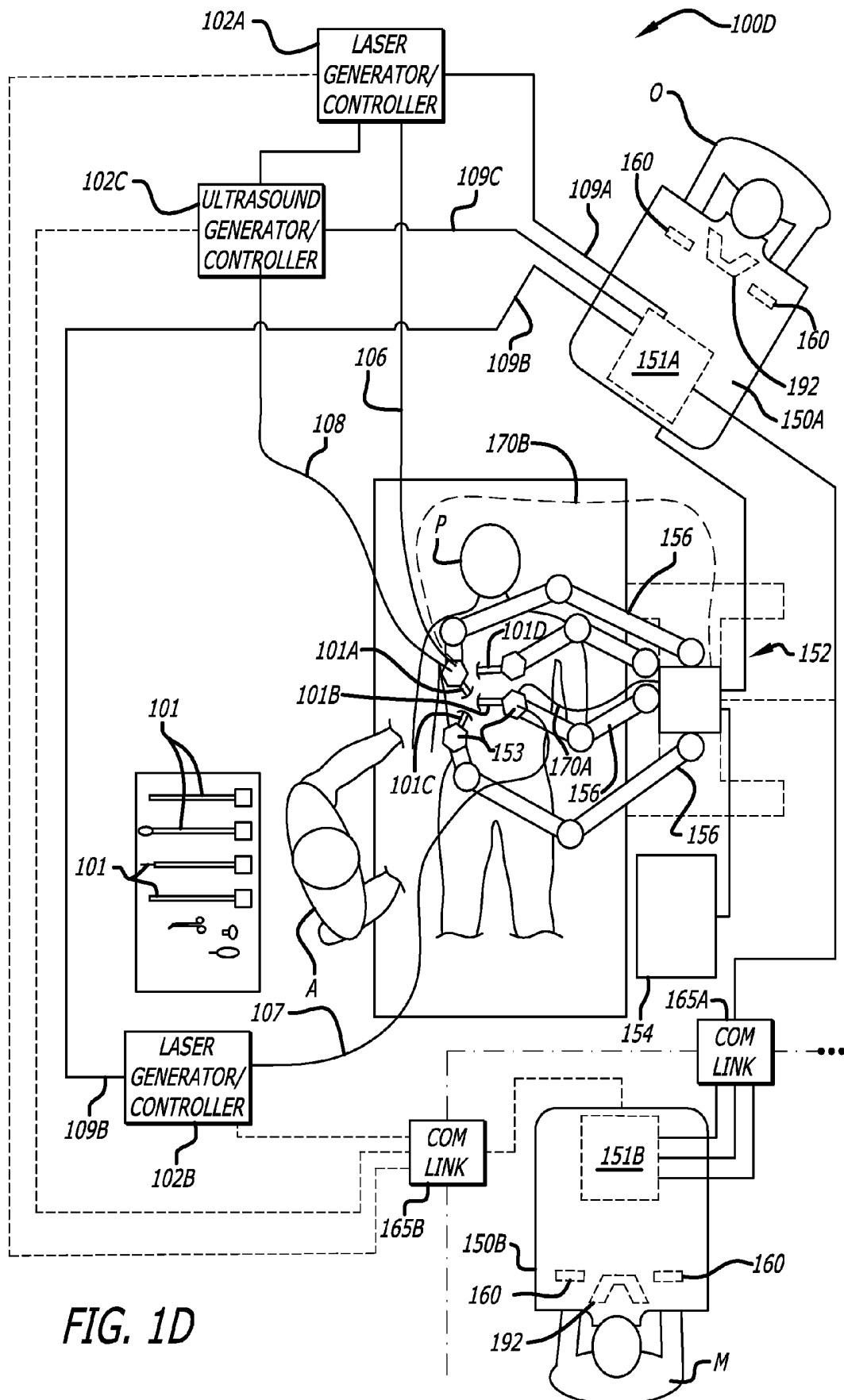
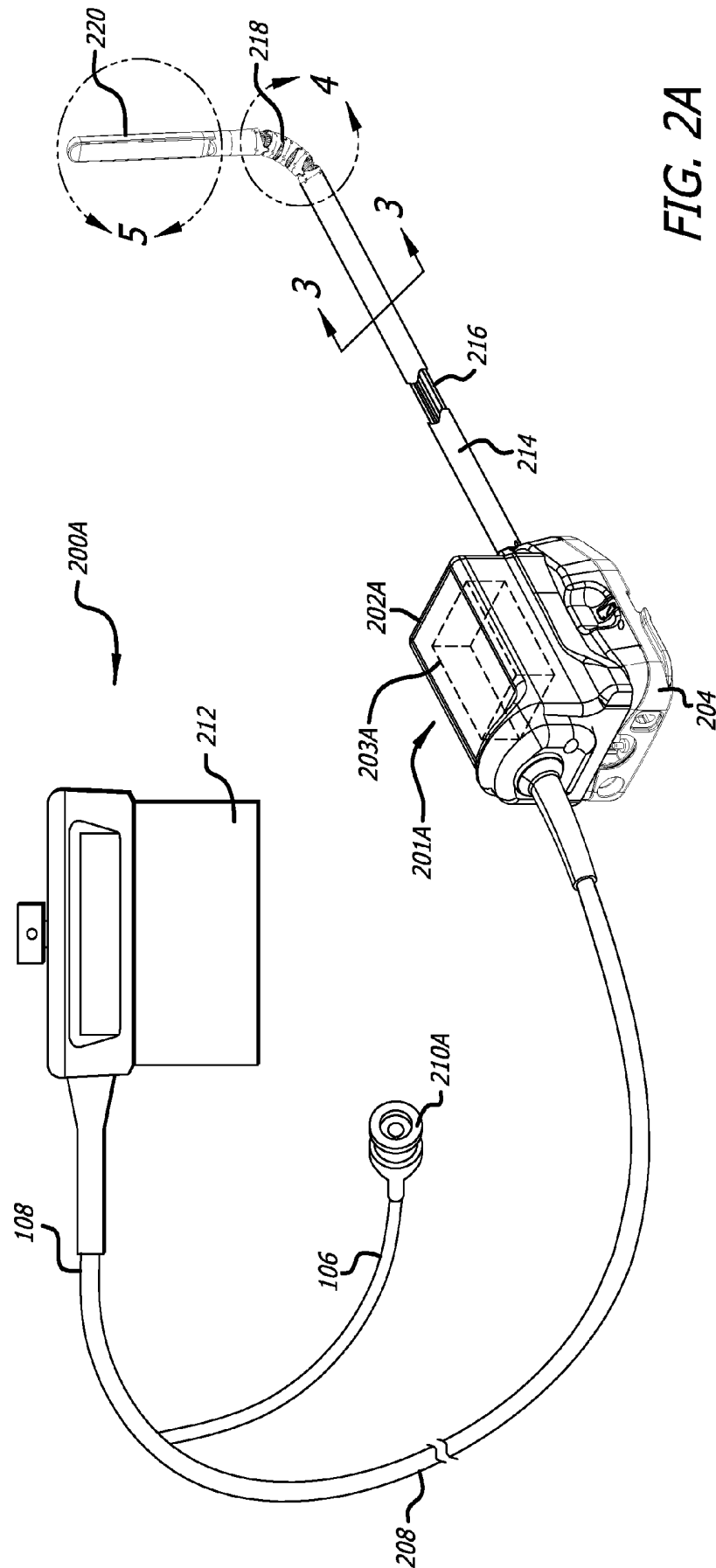
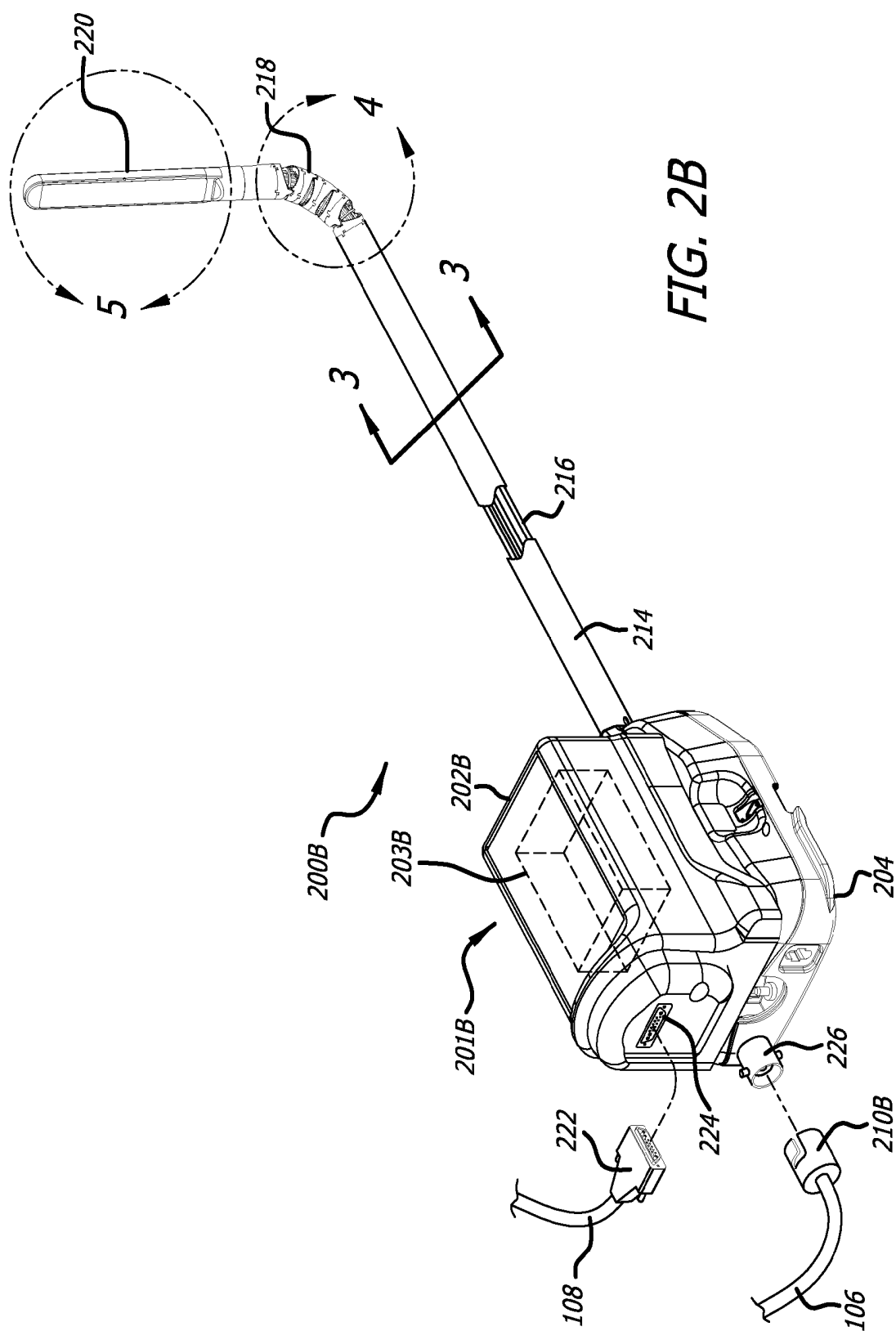
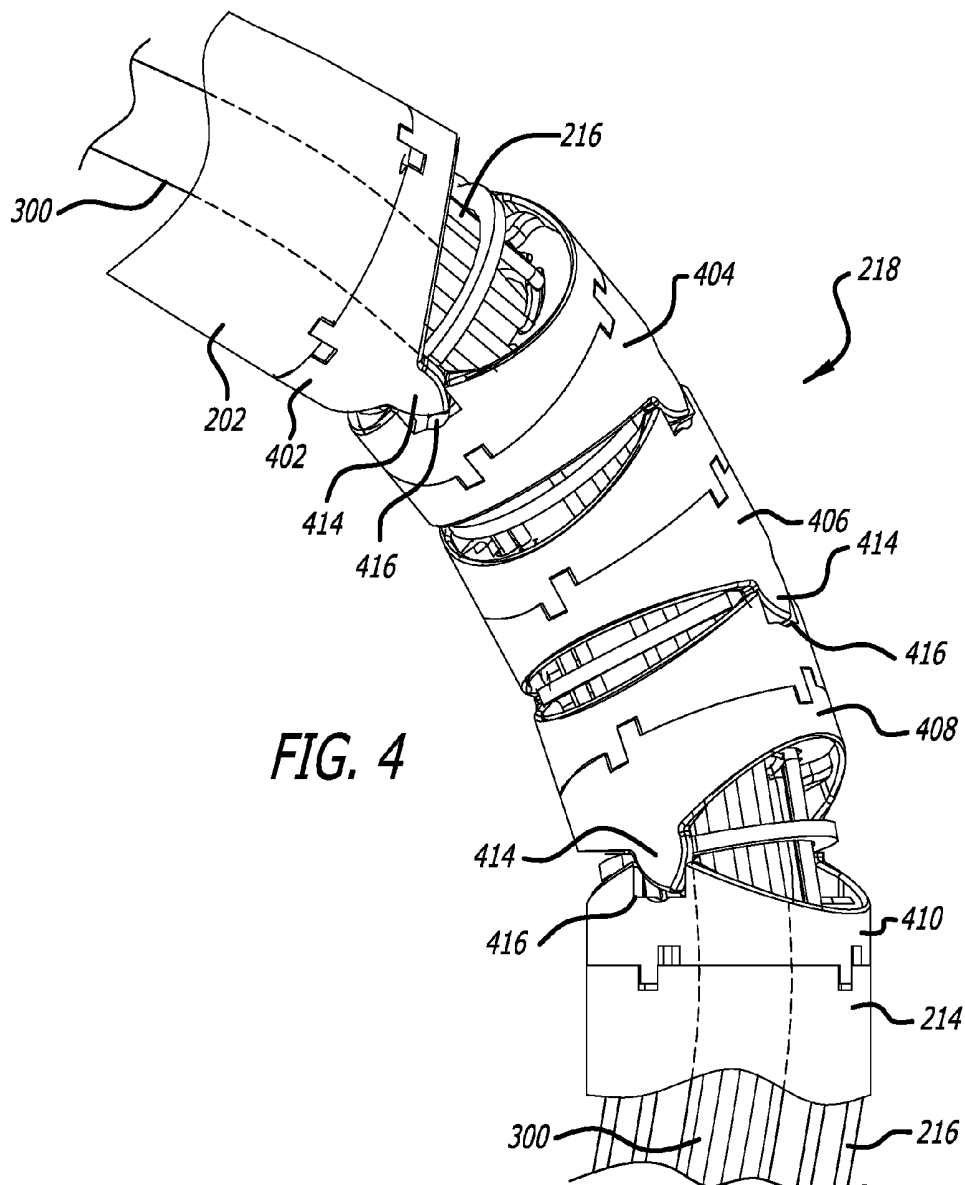
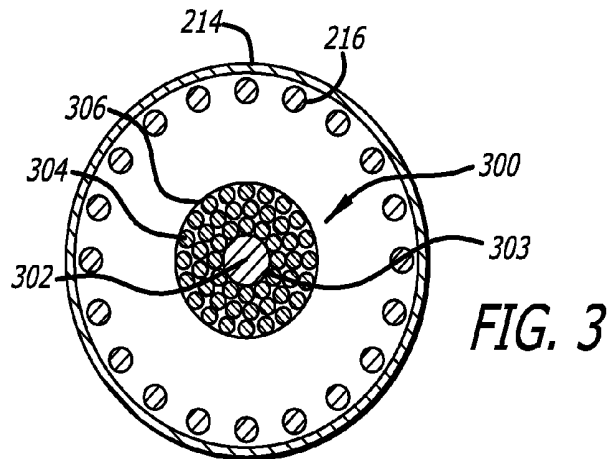


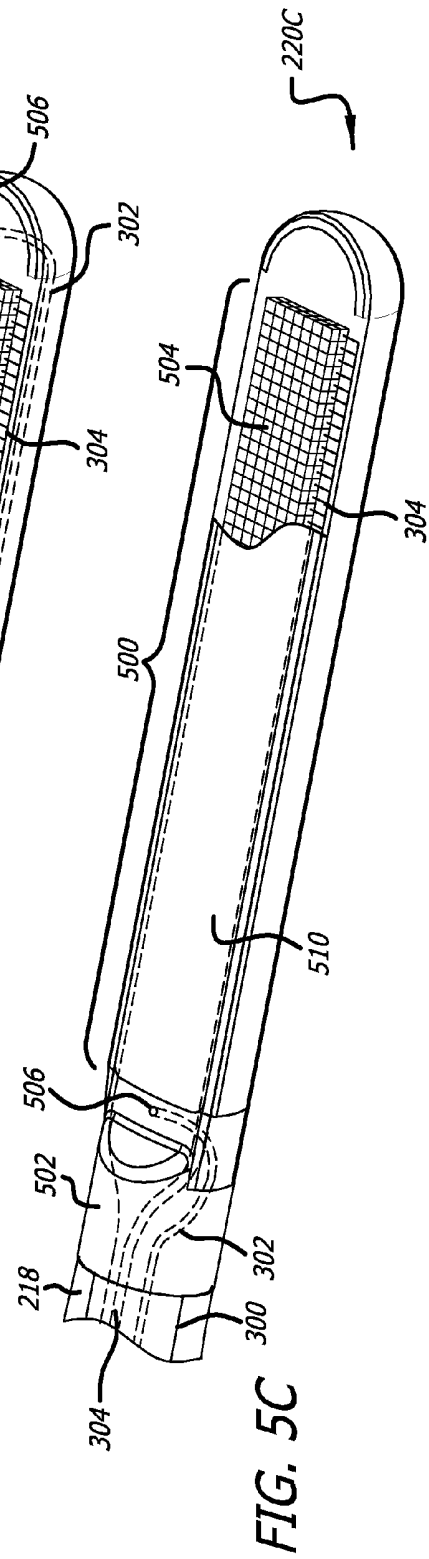
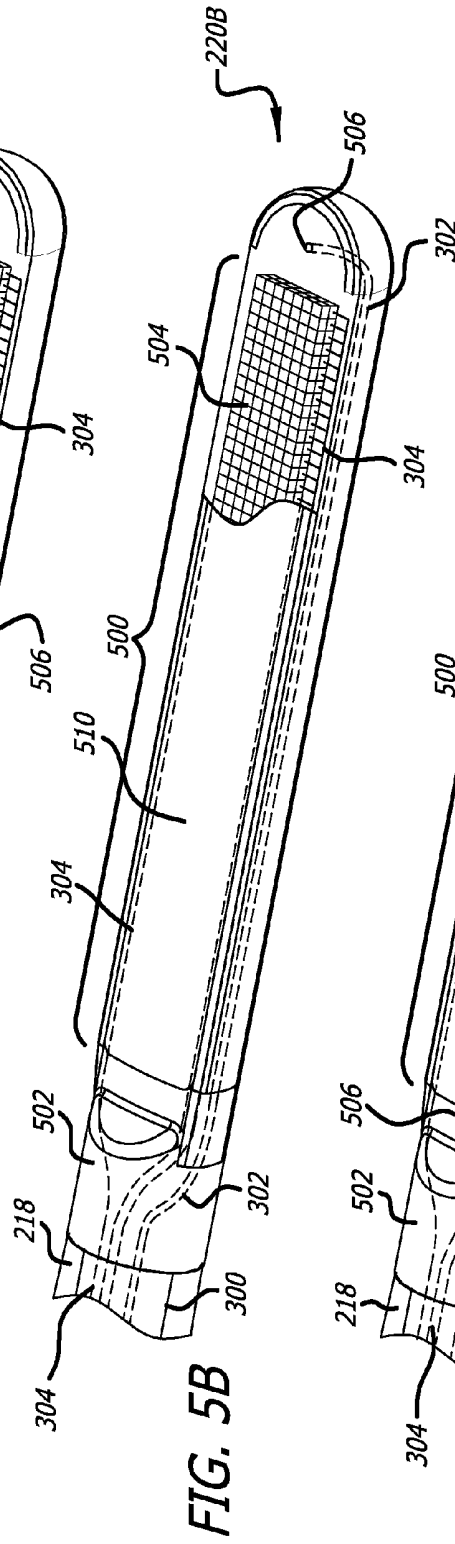
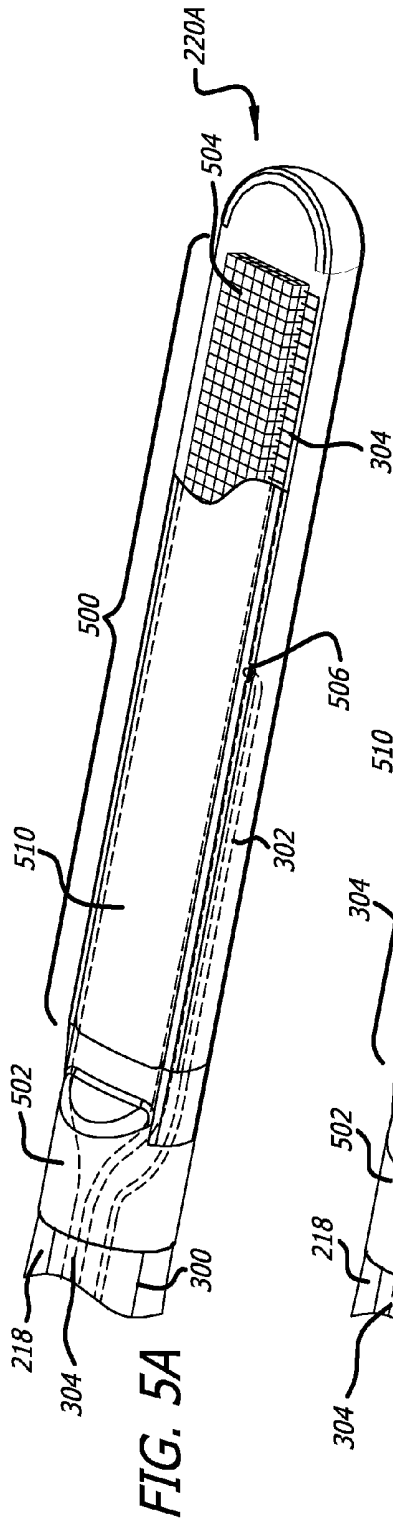
FIG. 1C











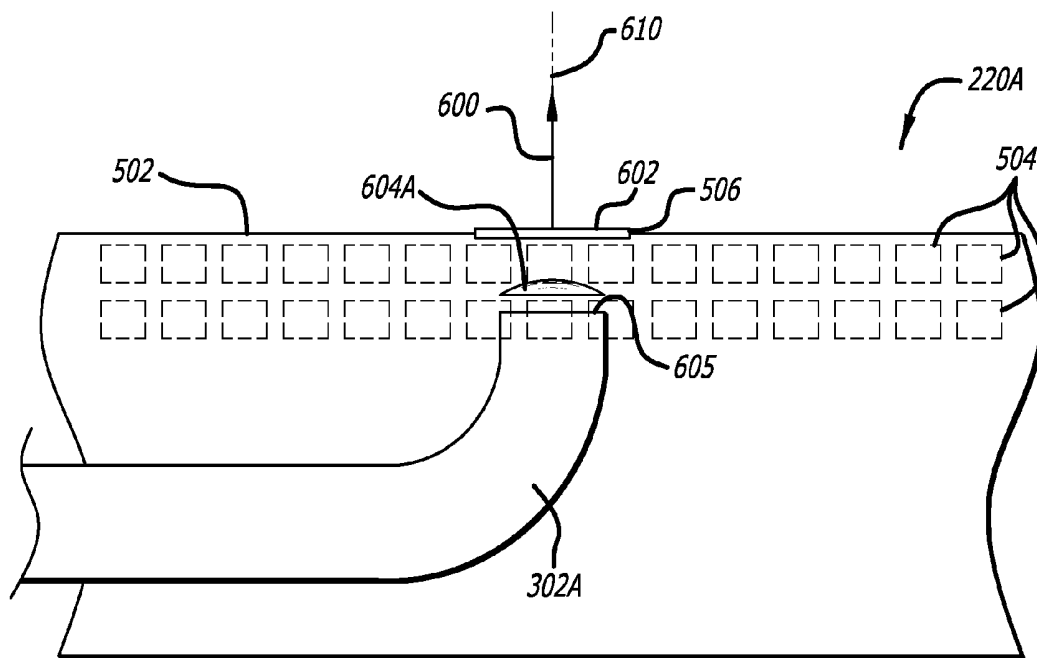


FIG. 6A

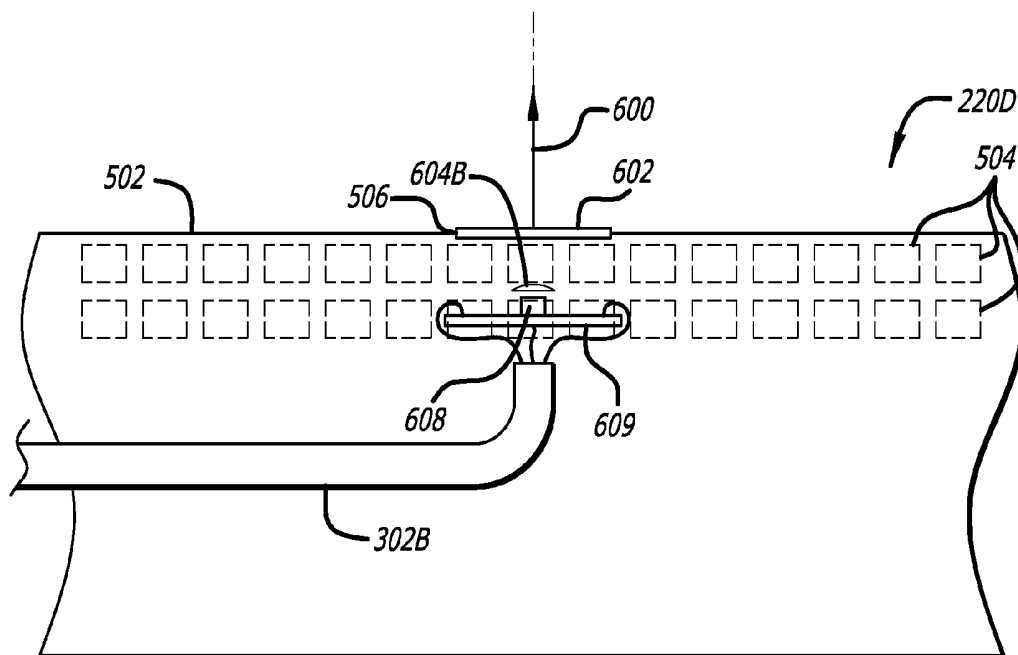
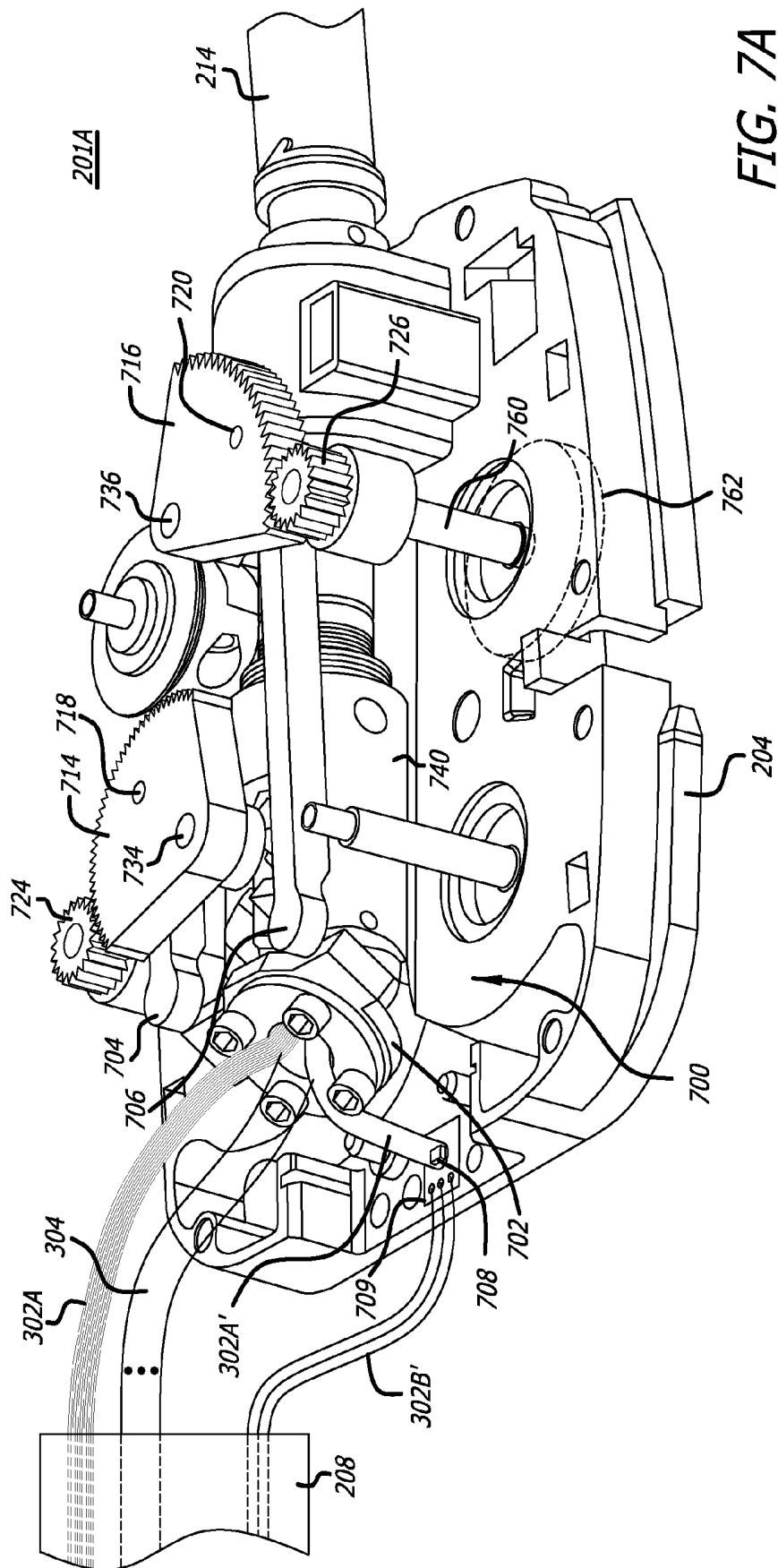
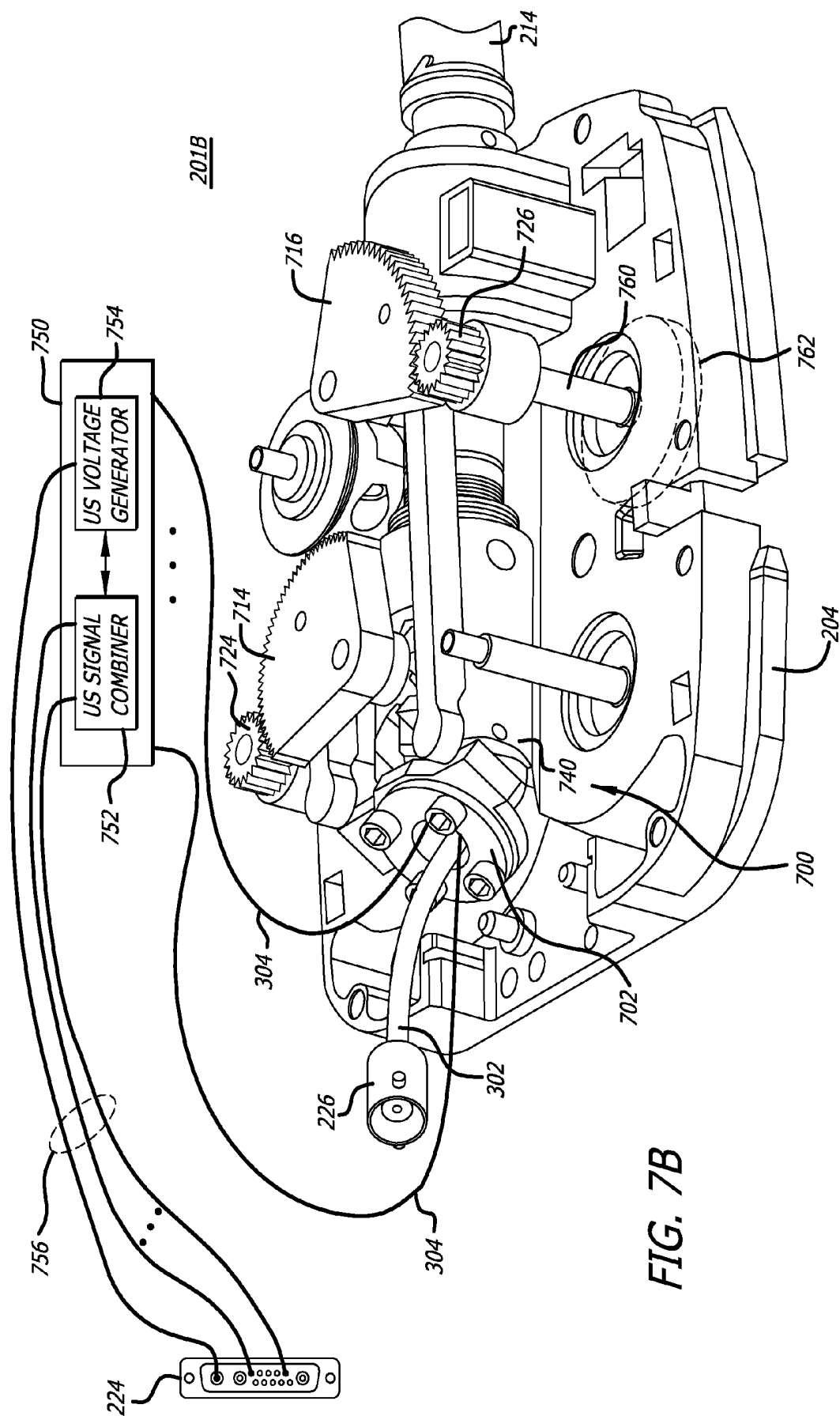


FIG. 6B





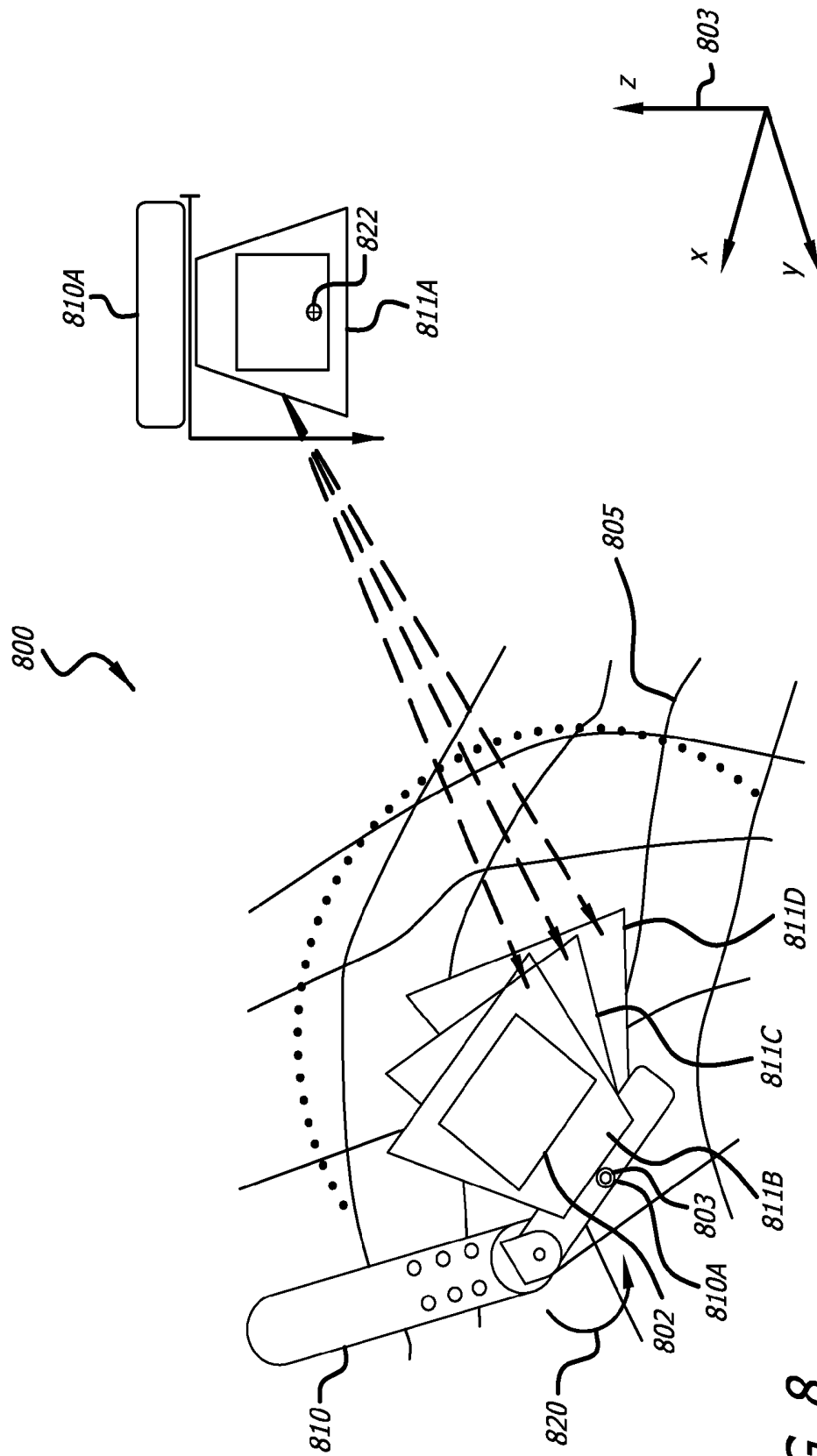
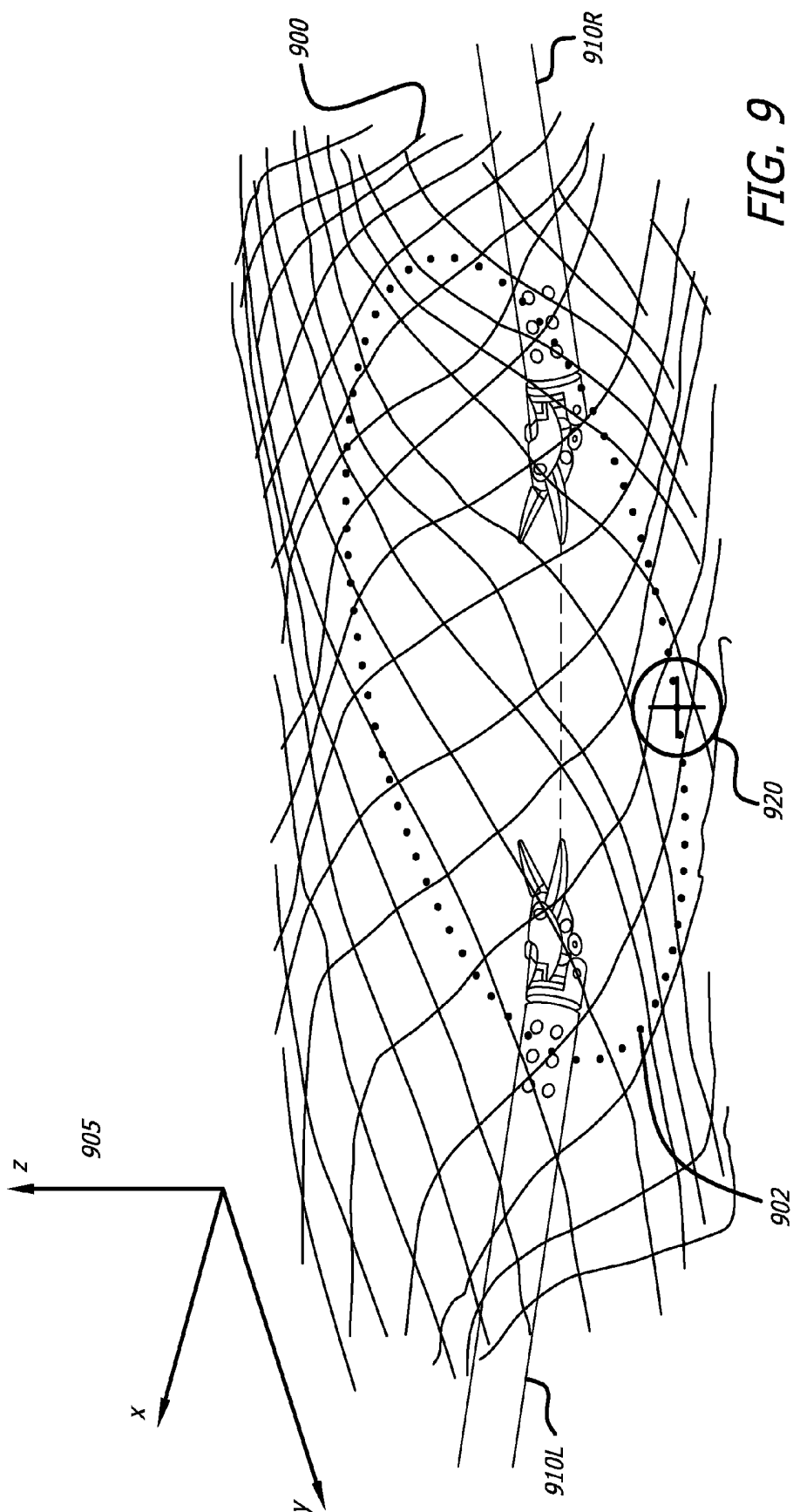
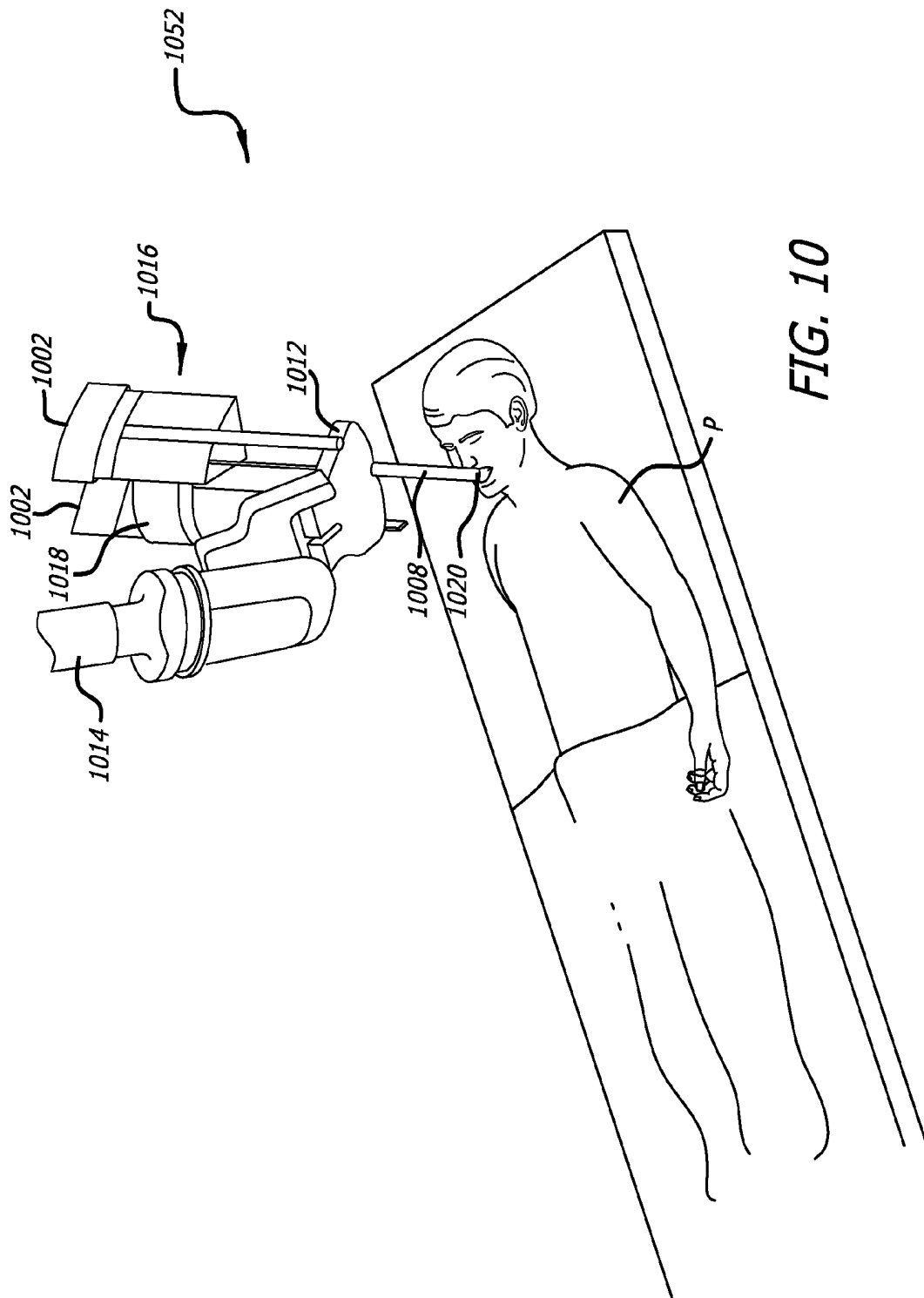
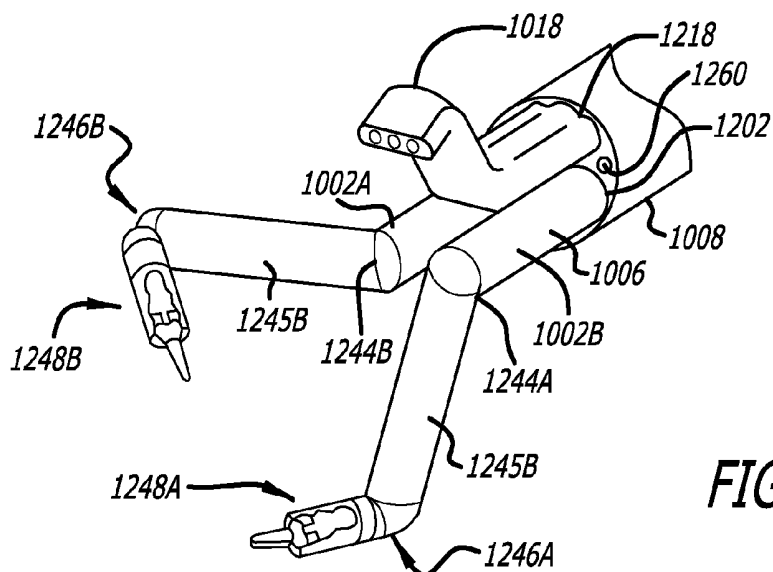
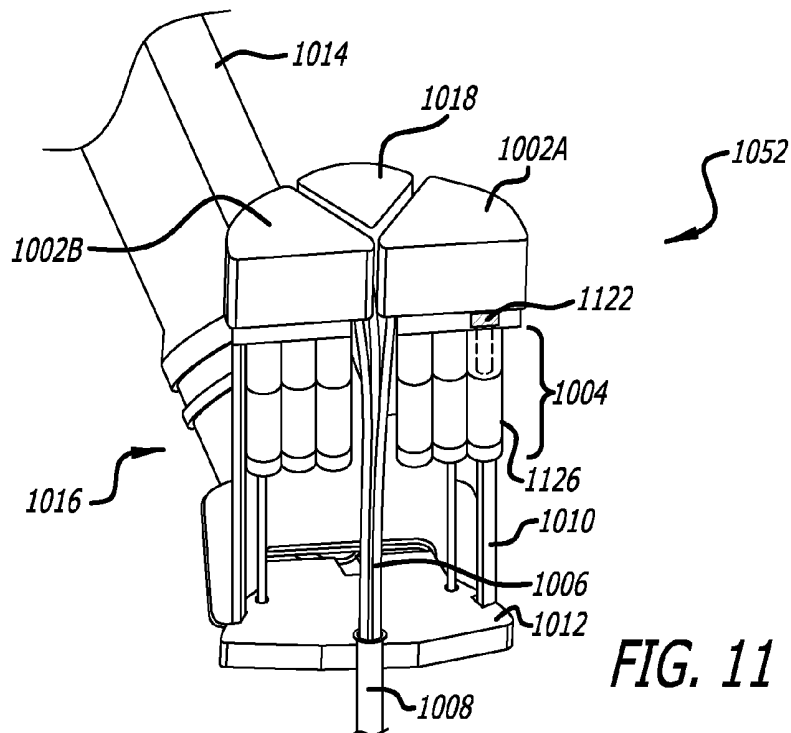


FIG. 8







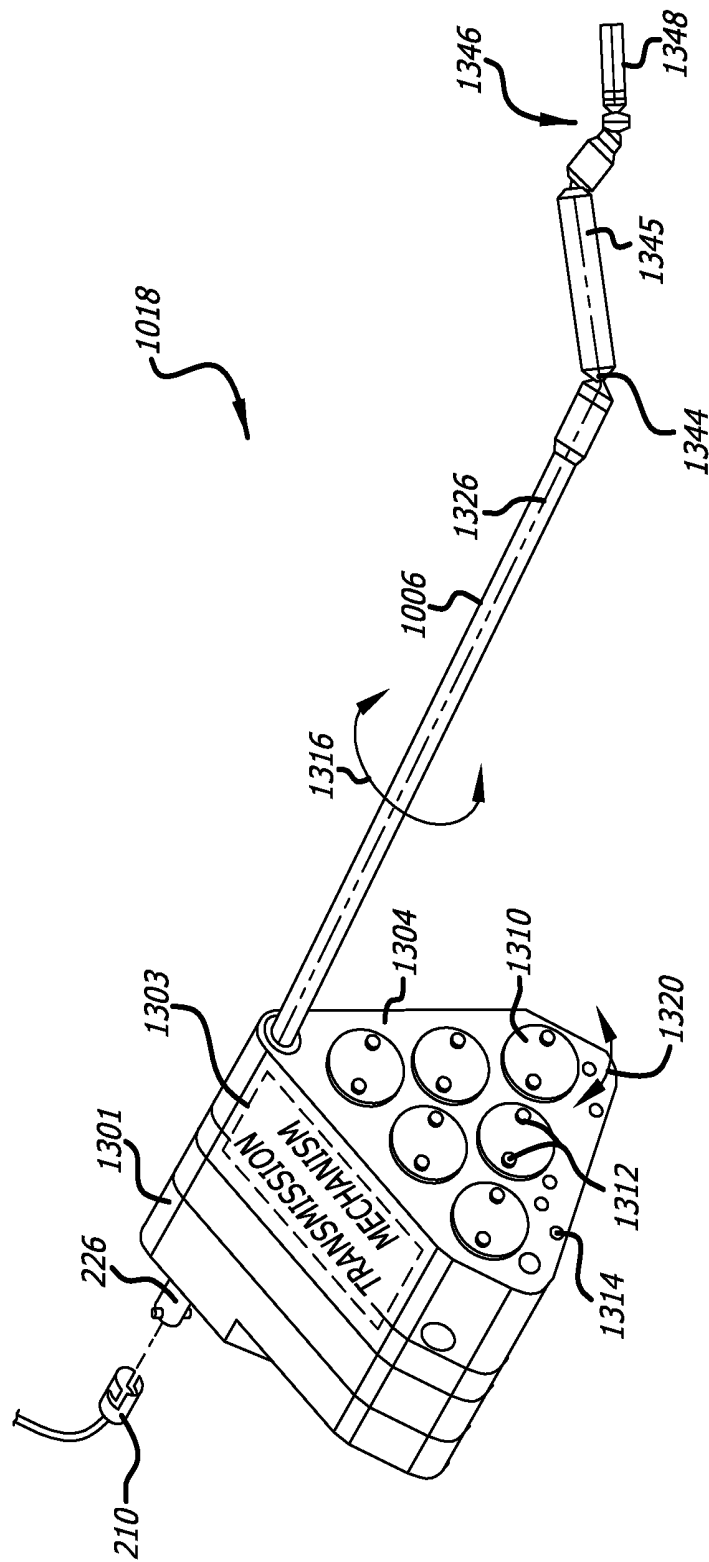


FIG. 13

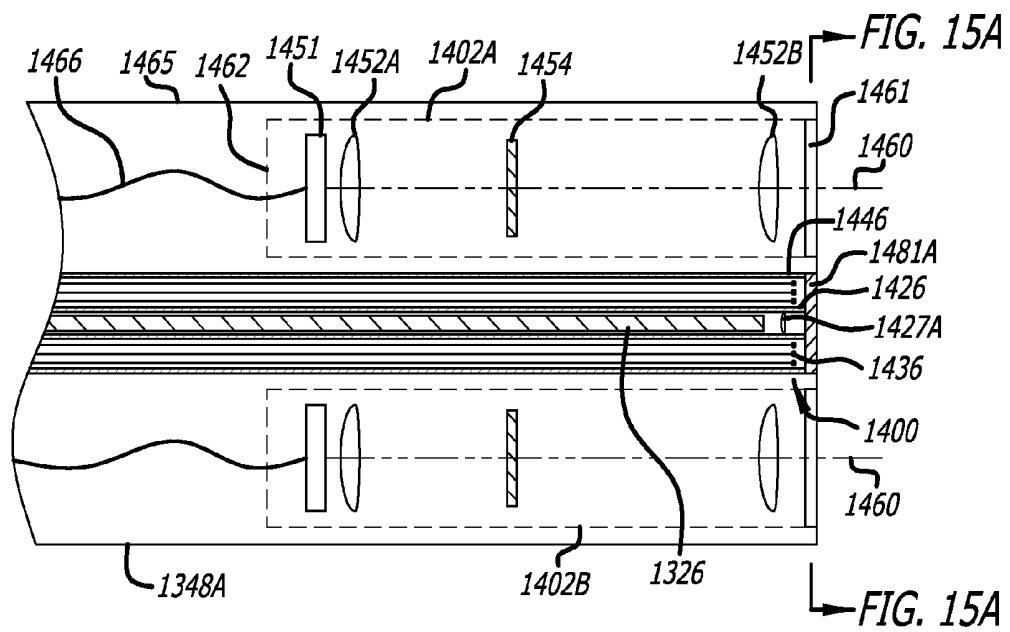


FIG. 14A

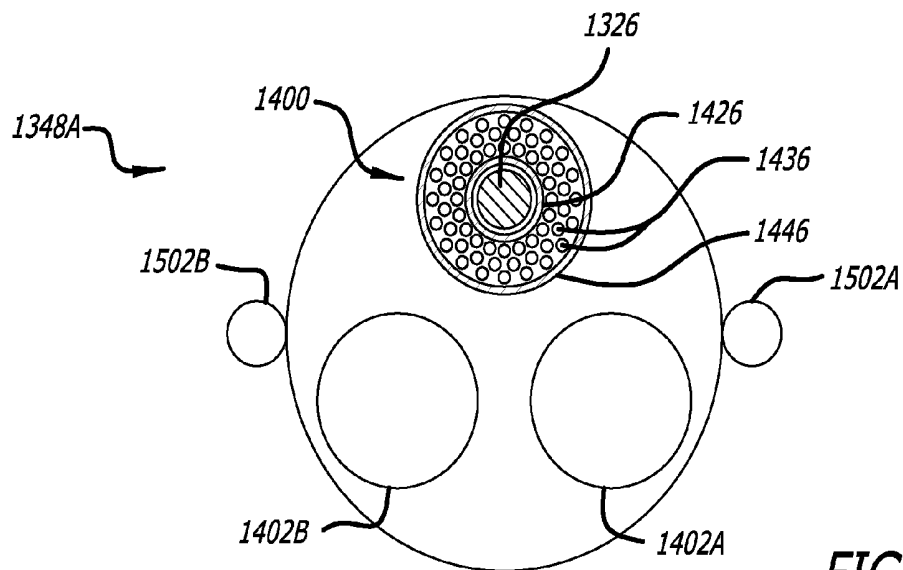
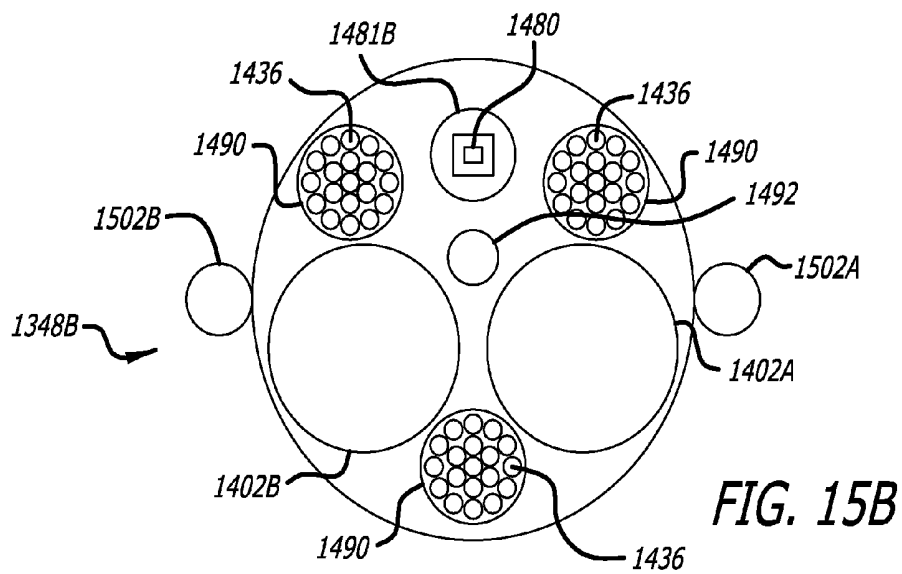
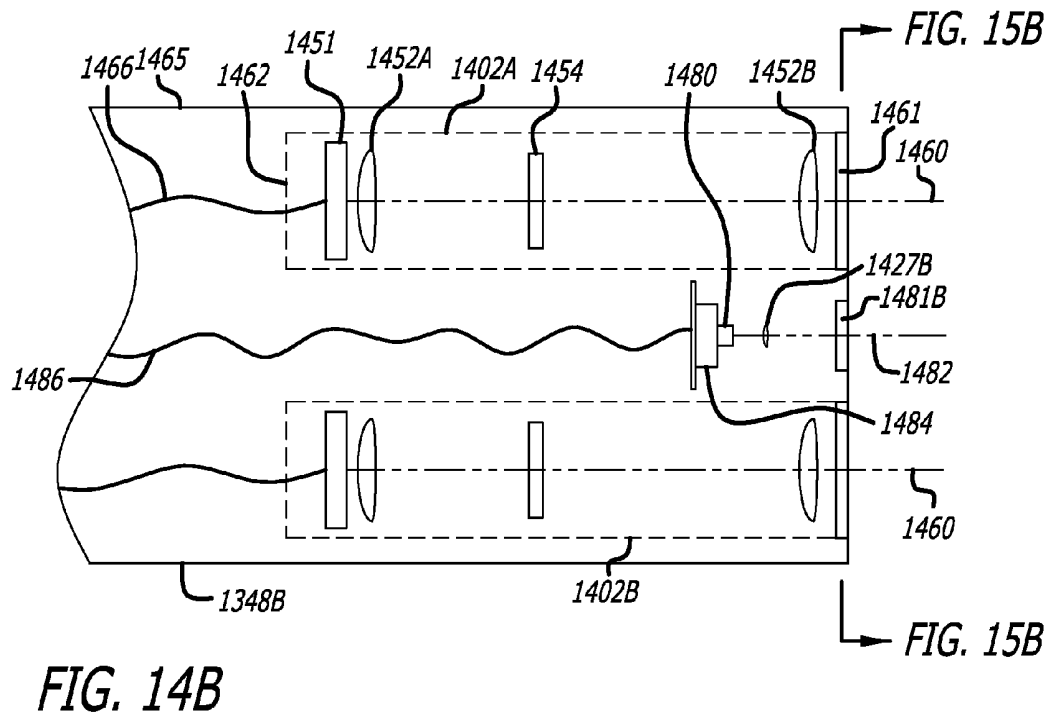


FIG. 15A



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SURGICAL TOOLS FOR LASER MARKING
AND LASER CUTTING

FIELD

The embodiments of the invention generally relate to robotic surgical instruments.

BACKGROUND

Minimally invasive medical techniques are aimed at reducing the amount of extraneous tissue that is damaged during diagnostic or surgical procedures, thereby reducing patient recovery time, discomfort, and deleterious side effects. The average length of a hospital stay for a standard surgery may also be shortened significantly using minimally invasive surgical techniques. Thus, an increased adoption of minimally invasive techniques could save millions of hospital days, and millions of dollars annually in hospital residency costs alone. Patient recovery times, patient discomfort, surgical side effects, and time away from work may also be reduced with minimally invasive surgery.

The most common form of minimally invasive surgery may be endoscopy. Probably the most common form of endoscopy is laparoscopy, which is minimally invasive inspection and surgery inside the abdominal cavity. In standard laparoscopic surgery, a patient's abdomen is insufflated with gas, and cannula sleeves are passed through small (approximately 1/2 inch) incisions to provide entry ports for laparoscopic surgical instruments. The laparoscopic surgical instruments generally include a laparoscope (for viewing the surgical field) and working tools.

In endoscopic surgery, the working tools are similar to those used in conventional (open) surgery, except that the working end or end effector of each tool is separated from its handle by an extension tube. As used herein, the term end effector means the actual working part of the surgical instrument and can include clamps, graspers, scissors, staplers, and needle holders, for example.

To perform endoscopic surgical procedures, the surgeon passes these working tools or instruments through the cannula sleeves to an internal surgical site and manipulates them from outside the abdomen. The surgeon may monitor the procedure within the internal surgical site by means of a laparoscope. Similar endoscopic techniques are employed in, e.g., arthroscopy, retroperitoneoscopy, pelviscopy, nephroscopy, cystoscopy, cisternoscopy, sinoscopy, hysteroscopy, urethroscopy and the like.

Minimally invasive surgeries are also being performed on other areas of the body including the neck and throat regions. The neck and throat is a highly visible region and scarring is undesirable for aesthetic and health privacy reasons, thus a minimally invasive procedure is desirable. A readily visible thyroid surgical scar may announce underlying health issues that a patient may not wish disclosed. Due to the lack of skin folds in the throat and neck region, hiding a surgical scar may be problematic. In warmer climes, it is preferable to avoid covering up throat surgery scars with clothing. Operating in a long narrow enclosed space such as the laryngopharynx is challenging due to space restrictions and the accessibility of the surgical site. In these cases, multiple entry ports may not be preferred because of visible scarring and limited space.

BRIEF SUMMARY

The embodiments of the invention are summarized by the claims that follow below.

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BRIEF DESCRIPTION OF THE DRAWING

FIG. 1A is a block diagram of a robotic surgery system to perform minimally invasive robotic surgical procedures with combined laser imaging robotic surgical tools.

FIG. 1B is a perspective view of the robotic patient-side system of FIG. 1A with combined laser imaging robotic surgical tools.

FIG. 1C is a perspective view of the robotic surgical master control console of FIG. 1A, 1D that is used to control the combined laser imaging robotic surgical tools.

FIG. 1D is a block diagram of a robotic surgery system with multiple robotic surgical master control consoles to control the combined laser imaging robotic surgical tools.

FIGS. 2A-2B illustrate perspective views of exemplary embodiments of combined laser ultrasound robotic surgical instruments.

FIG. 3 is a cross sectional view of the tool shaft of the exemplary embodiments of the combined laser ultrasound robotic surgical instruments illustrated in FIGS. 2A-2B illustrating the wires and cables routed therein.

FIG. 4 is a magnified side view of the wristed portion of the exemplary embodiments of combined laser ultrasound robotic surgical instruments illustrated in FIGS. 2A-2B.

FIGS. 5A-5C are magnified views of exemplary embodiments of the combined laser and ultrasound end effector of the exemplary embodiments of the combined laser ultrasound robotic surgical instruments illustrated in FIGS. 2A-2B.

FIGS. 6A-6B are magnified cutaway side views of exemplary embodiments of the combined laser and ultrasound end effector.

FIGS. 7A-7B are perspective views of a proximal end of exemplary robotic surgical tools with covers removed to show the cabling and connectors for the laser and ultrasound end effectors.

FIG. 8 is a diagram illustrating a combined laser ultrasound robotic surgical tool laser marking tissue in a surgical site.

FIG. 9 is a diagram illustrating the laser marking on tissue in the surgical site indicating where a surgeon may perform a minimally invasive surgical procedure with one or more robotic surgical tools.

FIG. 10 is a perspective view of a portion of a robotic patient-side system with a combined laser imaging robotic surgical tool for minimally invasive surgery through a single port.

FIG. 11 is another perspective view of the portion of the robotic patient-side system of FIG. 10 with the combined laser imaging robotic surgical tool.

FIG. 12 is a perspective view of a distal end portion of the robotic patient-side system of FIG. 10 with the combined laser imaging robotic surgical tool.

FIG. 13 is a perspective view of the combined laser imaging robotic surgical tool for use with the robotic patient side system of FIG. 11.

FIGS. 14A-14B are cutaway side views of embodiments of the end effector of the combined laser imaging robotic surgical tool.

FIGS. 15A-15B are bottom views of the embodiments of the end effector of FIGS. 14A-14B, respectively.

Similar reference numbers in the different drawings are associated with the same or similar elements but may have a different configuration.

DETAILED DESCRIPTION

This detailed description describes exemplary implementations that are illustrative of the invention, and so is

explanatory and not limiting. The invention is limited only by patented claims. In the drawings, some elements have been omitted to more clearly show the embodiments of the invention.

Introduction

The embodiments of the invention include an apparatus and system of robotic surgical instruments or tools used in robotic surgical systems with multiple capabilities. The robotic surgical tools include the capability to deliver laser energy for use in marking, cutting, or cauterizing tissue. A video camera, an ultrasound probe, or other imaging device is included with the robotic surgical tool to display an area of tissue in a surgical site where the laser energy may be delivered.

An end effector including both the laser and imaging device, are connected to a wristed joint capable of multiple degrees of freedom of movement. The wristed joint may use disks or vertebrae and actuation cables or tendons to allow a surgeon to remotely manipulate the end effector within small tight enclosures with a high degree of precision from a master control workstation or console. An exemplary wristed joint is described in detail in U.S. Pat. No. 6,817,974 entitled SURGICAL TOOL HAVING POSITIVELY POSITIONABLE TENDON-ACTUATED MULTI-DISK WRIST JOINT filed by Thomas G. Cooper et al. on Jun. 28, 2002 which is incorporated herein by reference.

One imaging device described in the embodiments of the invention may use an ultrasound probe to capture images of the surgical site. Ultrasonography utilizes sound waves emitted from transducers to form images. During transmit mode, acoustic energy is created by sending electrical signal to the transducer causing the elements of the transducer to resonate. The acoustic signal produced travel to nearby structures where some of the signal is absorbed and some reflected back to the transducer. In receive mode, the reverse occurs, i.e. reflected acoustic signals causes the transducer to resonate producing measurable electrical signals which can be processed into images.

The images produced by ultrasound may contain details not available to traditional laparoscopes using a light viewing scope. For example, ultrasound images may differentiate between healthy and cancerous cells based on a difference in acoustic impedance. Malignant lesions in thyroid and breast cancers are harder and stiffer than benign lesions and thus have a higher acoustic impedance that may be detectable by a trained physician or ultrasound technician.

Another image device described in the embodiments of the invention are video cameras to capture video images of the surgical site. A video camera captures images in the visible spectrum and uses a light source to illuminate the surface of tissue in a surgical site. A digital video camera with a charge-coupled device (CCD) may be used to capture digital video images of a surgical site. A bundle of optical fibers may be used as light pipes to direct a light source at one end down into the surgical site to provide the illumination to capture the digital video images. The video images captured by the camera may be transmitted to one or more viewing monitors that a surgeon uses to visualize the internal anatomy and guide any surgical procedures.

Note that while ultrasound imaging and video imaging are disclosed herein, other forms of imaging technology, such as X-ray, magnetic resonance, computed tomography, visible, infrared, and ultraviolet imaging, may also be used to display the surgical site depending on the needs of the

Robotic Surgical System for Ultrasound Imaging and Laser Cutting

Referring for a moment to FIG. 1A, a robotic surgical system **100A** is illustrated for performing ultrasound imaging and laser cutting/ablation during minimally invasive robotic assisted surgery. The robotic surgical system **100A** includes one or more control workstations or surgeon's consoles **150A**, a patient side manipulator or patient side cart **152**, and one or more robotic surgical instruments or tools **101A-101D** (generally referred to by reference number **101**) coupled to the patient side cart via robotic surgical arms **153** and set up arms **156**. The set up arms **156** are passive arms that are fixed into an initial position to support the robotic surgical arms. The robotic surgical arms **153** may be moved under commands from the surgeon's console to manipulate the positions of the tools **101A-101D** and perform minimally invasive robotic assisted surgery.

The robotic surgical tools **101** may include such end effectors as clamps, graspers, scissors, staplers, needle holders, cameras, ultrasound imagers, and laser ablation/cutting/marking. The robotic surgical tools **101** may combine a plurality of capabilities into one tool and end effector. For example, the robotic surgical tool **101A** may combine an ultrasound imaging and a laser marking capability together into one tool. As another example, the robotic surgical tool **101B** may include one or more video cameras and a laser ablation/cutting capability combined into one tool. The robotic surgical tools **101C-101D** may be tissue manipulation tools such as to grasp, cut, or suture tissue together, for example.

The robotic surgical tools **101** may be mounted to and dismounted from the robotic surgical arms **153** of the patient side cart **152**. The patient side cart **152** is in turn coupled to the surgeon's console **150A**. Commands from the surgeon's console **150A** are coupled to the patient side cart **152** to generally control the robotic surgical tools **101**. The robotic surgical tools **101** may send signals back to the surgeon's console **150A** such that commands from the workstation **150A** may be transmitted to the cart **152**. To perform robotic assisted surgeries, the patient side cart **152** is positioned adjacent to a patient P as illustrated in FIG. 1A.

The robotic surgical system **100A** further includes one or more laser generator/controllers **102A-102B** and an ultrasound generator/controller **102C** to couple to the robotic surgical tools **101A-101B** to perform ultrasound imaging and laser cutting/ablation during minimally invasive robotic assisted surgery. The laser generator/controller **102A** is coupled to the robotic surgical tool **101A** by a cable **106**. The ultrasound generator/controller **102C** is coupled to the robotic surgical tool **101A** by a cable **108**. The laser generator/controller **102B** is coupled to the robotic surgical tool **101B** by a cable **107**. To control the ultrasound imaging and laser cutting/ablation during minimally invasive robotic assisted surgery, the one or more laser generator/controllers **102A-102B** and the ultrasound generator/controller **102C** are coupled to a computer **151A** in the surgeon's console **150A**. The laser generator/controllers **102A-102B** are respectively coupled to the computer **151A** in the surgeon's console **150A** by cables **109A-109B**. The ultrasound generator/controller **102C** is coupled to the computer **151A** in the surgeon's console **150A** by a cable **109C**.

The power levels and wavelengths of the laser light generated by the laser generator/controllers and/or laser diodes to laser ablate/cut body tissue may vary. For example, typical power level ranges for laser ablation/cutting are (i) three to six (3-6) watt range for fine tissue dissection, not particularly wavelength dependent; (ii) ten to fifteen (10-15)

watt range for larger dissections with approximately two micron wavelength; (iii) twenty-five to sixty (25-60) watt range with approximately 532 nano-meters (nm) (green light) wavelength; and (iv) up to sixty (60) watt for carbon dioxide (CO₂) laser (approximately ten and six tenths (10.6) micron wavelength). If the laser is to be used for marking tissue, the power level may be less, such as around one watt with approximately a two-micron wavelength.

Referring now to FIG. 1B, the patient side cart 152 includes a plurality of robotic arms 153 to which the robotic surgical tools 101A-101C are removeably coupled. The interface between the robotic surgical tools 101A-101C and the robotic surgical arms 153 is the same (e.g., standardized) so that the tools are interchangeable. The movement of the robotic surgical arms 153 may be adapted to manipulate interchangeable surgical instruments, such as laser surgical tools, optical sensors, acoustic sensors, patient telemetry sensors as the need arises. Each robotic surgical arm 153 may include a sled 177 with drive mechanisms to control the position of the robotic surgical tools and the associated end effectors, if any. The sled 177 may be moved along an insertion axis parallel to the shaft of the tool as indicated by the double-headed arrow 179.

Referring now to FIG. 1C, a perspective view of the robotic surgical master control console 150 is illustrated. The master control console 150 of the robotic surgical system 100 may include the computer 151, a binocular or stereo viewer 192, an arm support 194, a pair of control inputs (control input wrists and control input arms) 160 in a workspace 196, foot pedals 198 (including foot pedals 198A-198B), and a viewing sensor 193. The master control console 150 may also be referred to as a surgeon's console or workstation.

The master control console 150 provides substantial dexterity to a surgeon while working within an internal surgical site. The master control console 150 controls the motion of the servo-mechanically operated robotic surgical instruments 101. During the surgical procedure, the telesurgical system can provide mechanical actuation and control of a variety of robotic surgical instruments or tools 101 having end effectors, such as tissue graspers, needle drivers, or the like. The robotic surgical instruments or tools 101 perform various functions for the surgeon, such as holding or driving a needle, grasping a blood vessel, or dissecting tissue, or the like, in response to manipulation of the master control devices 160.

The master control console 150 allows one or more surgeons to remotely operate on a patient by providing images of the surgical site at the master control console 150. The stereo viewer 192 has two displays where stereo three-dimensional images of the surgical site may be viewed to perform minimally invasive surgery. When using the master control console, the operator O typically sits in a chair, moves his or her head into alignment with the stereo viewer 192 to view the three-dimensional images of the surgical site. To ensure that the operator is viewing the surgical site when controlling the robotic surgical tools 101, the master control console 150 may include the viewing sensor 193 disposed adjacent the binocular display 192. When the system operator aligns his or her eyes with the binocular eyepieces of the display 192 to view a stereoscopic image of the surgical worksite, the operator's head sets off the viewing sensor 193 to enable the control of the robotic surgical tools 101. When the operator's head is removed the area of the display 192, the viewing sensor 193 can disable or stop generating new control signals in response to movements of the touch sensitive handles in order to hold the state of the

robotic surgical tools. While viewing a three-dimensional image of the surgical site on the stereo view 192, the surgeon performs the surgical procedures on the patient by manipulating the master input devices of the workstation.

The arm support 194 can be used to rest the elbows or forearms of the operator O (typically a surgeon) while gripping touch sensitive handles of the control input 160, one in each hand, in the workspace 196 to generate control signals. The touch sensitive handles 160 are positioned in the workspace 196 disposed beyond the arm support 194 and below the viewer 192. This allows the touch sensitive handles to be moved easily in the control space 196 in both position and orientation to generate control signals. Additionally, the operator O can use his feet to control the foot-pedals 198 to change the configuration of the surgical system and generate additional control signals to control the robotic surgical instruments.

The computer 151 may include one or microprocessors 182 to execute instructions and a storage device 184 to store software with executable instructions that may be used to generate control signals to control the robotic surgical system 100. The computer 151 with its microprocessors 182 interprets movements and actuation of the touch sensitive handles (and other inputs from the operator O or other personnel) to generate control signals to control the robotic surgical instruments 101 in the surgical worksite. In one embodiment of the invention, the computer 151 and the stereo viewer 192 map the surgical worksite into the controller workspace 196 so that it feels and appears to the operator O that the touch sensitive handles 160 are working over the surgical worksite.

The robotic surgical instruments 101A-101B on the robotic arms 158A-158B typically include elongated shafts, with proximal and distal ends. End effectors are generally mounted on wrist-like mechanisms pivotally mounted on the distal ends of the shafts, for enabling the instruments to perform one or more surgical tasks. Generally, the elongated shafts of surgical instruments allow the end effectors to be inserted through entry ports in a patient's body to access the internal surgical site. Movement of the end effectors is generally controlled via master controls on the control console 150.

Further information regarding robotic surgical systems may be found for example in U.S. Pat. No. 6,331,181, entitled SURGICAL ROBOTIC TOOLS, DATA ARCHITECTURE, AND USE, issued to Tierney et al on Dec. 18, 2001, which is incorporated by reference.

Robotic Surgical System with Remote Workstation

Referring for the moment to FIG. 1D, a robotic surgical system 100D is illustrated for performing ultrasound imaging and/or laser marking/cutting/ablation during minimally invasive robotic assisted surgery. The robotic surgical system 100D differs from the robotic surgical system 100A in that a second surgeon's console 150B may also be used to control the robotic surgical tools 101 and receive signals therefrom. The second workstation 150B allows another user (e.g., a second surgeon) to assist in robotic assisted surgical procedures on patients, such as if there are multiple tools being used and extra hands are needed to control those robotic surgical tools.

For example, the second surgeon's console 150B may be used to control the robotic surgical tool 101A that combines an ultrasound imaging and a laser marking capability together into one tool. A second surgeon or mentor at the second surgeon's console 150B may view ultrasound images and laser mark corresponding tissue in a body cavity for viewing by the first surgeon at the first surgeon's console

150A. Alternatively, the second surgeon at the second surgeon's console 150B may operate a laser in an end effector of a robotic surgical tool to cut or ablate tissue in a body while the first surgeon is operating other tools with his two hands.

The second surgeon's console 150B may be located remotely a distance away from the first surgeon's console 150A. The remote workstation 150B may be situated in another part of the medical facility or may be further removed and part of a greater network of remote workstations. In this case, second surgeon's console 150B may be connected as part of the surgical system through one or more communication links 165A-165B to the workstation 150A, the cart 152, and/or the generator/controllers 102A-102C.

The remote workstation 150B may be capable of indirect control of the robotic surgical tools 101 and their generator/controllers 102A-102C through the computer 151A of the workstation 150A. Optionally the remote workstation 150B may directly control the robotic surgical tools 101 and their respective generator/controllers 102A-102C.

Remote workstation 150B may have the same controls as workstation 150A including controls 160 for movement of a robotic surgical tool with an ultrasound probe and a display 192 to view images from one or more cameras and the ultrasound probe. Other controls on the surgeon console 150A and the remote workstation 150B may allow the surgeon to operate a robotic surgical tool with a laser-emitting device. The laser generator may be triggered, focused, and/or selectively powered (increase or decrease the power of the laser emitted) by using the controls on the workstation 150A or the controls of the extra workstation 150B.

For example, the robotic surgical tools 101A-101B may be combined laser-endoscopic cameras each having a camera and a laser-emitting device. Video images may be captured by the pair of cameras in the combined laser-endoscopic camera tools 101A-101B and coupled to the system via the video cables 170A-170B. Both sets of video images captured by the pair of cameras may be displayed at both surgeon consoles 150A-150B by the stereo viewer 192 of each and at the remote or assistant display 154. The laser functionality of the combined laser-endoscopic camera tools 101A-101B may be used as a laser-pointing device with a lower power laser light. The laser generator may be set to low power or the combined laser-endoscopic camera tool 101A-101B may include a low power laser diode. The mentoring surgeon M at the remote workstation 150B may control the combined laser-endoscopic camera tool 101A to point out anatomy in the patient P to the surgeon O at the local workstation 150A and those (e.g., assistant A or medical students in a remote location) watching the display 154. The operating surgeon O at the local workstation 150A may control the combined laser-endoscopic camera tool 101B to point out anatomy in the patient P to the surgeon M at the remote workstation 150A and those (e.g., assistant A or medical students in a remote location) watching the display 154. In this manner with both the operating surgeon O and the mentoring surgeon M, the may each use laser pointer devices provided by the combined laser-camera tools to discuss anatomy, such as for mentoring or proctoring.

Further information regarding a remote workstation for robotic surgical systems is found in U.S. patent application Ser. No. 11/322,866, entitled STEREO TELESTRATION FOR ROBOTIC SURGERY, filed by Ben Hambrecht et al. on Dec. 30, 2005, which is incorporated by reference.

Robotically Controlled Ultrasound Imaging and Laser Tool

Referring now to FIG. 2A, a perspective view of a combined laser-ultrasound robotic surgical tool 200A is illustrated. The combined laser-ultrasound robotic surgical tool 200A has multiple capabilities to provide ultrasound imaging and laser cutting/marking.

The combined laser-ultrasound robotic surgical tool 200A includes a mountable housing 201A, a system cable 208, a laser cable 106, a laser cable connector 210A, an ultrasound cable 108, an ultrasound cable connector 212, a hollow rotatable cylindrical shaft 214, a wristed joint 218, and a combined laser-ultrasound end effector 220 coupled together as shown in FIG. 2A. With the combined laser-ultrasound end effector 220 coupled to the wristed joint 218, the end effector 220 can be moved over multiple degrees of freedom in response to a surgeon's input from the console 150A, 150B.

The mountable housing 201A includes a mountable base 204 and a housing cover 202 coupled to the base. The mountable base 204 can be mounted to and dismounted from the sled 177 (see FIG. 1B) to couple and decouple the tool 200 to/from the robotic surgical arm. This allows the tool to be quickly changed to another type of tool during surgery. Additionally, it allows the tool to be changed out for maintenance or sterilization after surgery. The mountable housing 201A includes rotatable receivers (e.g., see rotatable receivers 1310 in FIG. 13) extending from the base 204 to interface to rotatable drivers (e.g., see rotatable driver 1122 in FIG. 11) of the sled 177 and a robotic surgical arm. The rotatable receivers receive a torque to rotate the shaft 214 and to control the wristed joint 218 to move the end effector 220. Actuators coupled to the base 204 receive the torque and translate it like a transmission to actuating cables 216 to control the wristed joint 218 and move the end effector 220.

The system cable 208 coupled to the tool 200 exiting from the mountable housing 201A includes the ultrasound cable 108 and the laser cable 106. The ultrasound cable 108 further includes a plurality of ultrasound signal wires 304. The laser cable 106 may include an optical fiber for carrying laser light from a laser generator/controller (e.g., see laser generator/controllers 102A, 102B illustrated in FIG. 1B) through the tool 200 to exit out through an aperture in the end effector 220. Alternatively, the laser cable 106 may include signal wires and/or power wires to power and control a laser diode to generate the laser light in the tool 200 for exit from the aperture in the end effector 220. The laser cable connector 210A is connected to an end of the laser cable 106 to couple an end of an optical fiber or alternatively wires therein to a laser generator/controller (e.g., see laser generator/controllers 102A, 102B illustrated in FIG. 1B).

In the case of an optical fiber within the cable 106, the laser generator/controller provides the laser light of the desired wavelength and power that is coupled into the optical fiber. In the case of wires within the cable 106, the laser generator/controller provides power, ground, and control signals to control a laser diode within the tool that generates the laser light of the desired wavelength and power. In either case, the laser generator/controller is controlled by a surgeon or user at a control console 150A, 150B to generate the laser light when desired with the desired wavelength and range of power.

The ultrasound cable connector 212 is connected to an end of the ultrasound cable 108 to couple its ultrasound signal wires 304 to an ultrasound generator/controller (see ultrasound generator/controller 102C illustrated in FIG. 1B). An opposite end of the signal wires 304 in the cable 108 may couple to the ultrasound transducer elements (see ultrasound

transducer elements **504** illustrated in FIGS. 5A-C) in the end effector **220**. Alternatively, the opposite end of the signal wires **304** may couple to circuits to combine signals together for routing through the tool down the shaft **214** to and from the ultrasound transducer elements.

The ultrasound controller/generator **102C** provides a drive signal to ultrasound transducers in the end effector **220** to cause them to emit ultrasonic energy. The ultrasound transducers in the end effector **220** further receive reflected ultrasound waves and converts them into electrical signals that are coupled back to the ultrasound generator/controller **102C** for processing of the return signals received by the transducers. The ultrasound controller/generator **102C** may form ultrasound images out of the return signals and provide video images over the cable **109C** for display to the surgeon at the console **150A**, **150B**. An ultrasound controller/generator **102C** and the ultrasound connector **212** are described in detail in U.S. Pat. No. 5,630,419 entitled SEALING CONNECTOR FOR MULTICONDUCTOR CABLES issued to Ranalletta, Joseph V on May 20, 1997, which is incorporated herein by reference.

The mountable housing **201A** is the interface of the tool with a robotic surgical system such as the DaVinci Surgical System by Intuitive Surgical. Amongst other things, the mountable housing **201A** includes the drive mechanisms or transmission under a cover **201A** to move drive cables **216** which in turn move the wristed joint **218**. An embodiment of the wristed joint or wrist member **218** is better illustrated by FIG. 4. The mountable housing **201A** may further include an isolation chamber **203A** under the cover to isolate electrical connections and cables from the drive mechanisms or transmission for the drive cables **216**.

A proximal end of the hollow cylindrical shaft **214** is pivotally (rotatably) coupled to the base **204** of the mountable housing **201A**. A proximal end of the wristed joint **218** is coupled to the distal end of the shaft **214**. The end effector **220** is coupled to a distal end of the wristed joint **218**. Note that the shaft **214**, the joint **218**, and the end effector **220** may rotate together to provide an additional freedom of movement for the end effector. The shaft **214** is a hollow cylindrical tube that extends the reach of combined laser-ultrasound end effector **220**.

The drive cables **216** are routed within the shaft **214** and may extend over its length from the base **204** to the wristed joint **218**, or extend further to an end effector. The drive cables **216** are typically arranged within the shaft to move nearer its inner surface away from a center axis of the shaft **214** as shown in FIG. 3. This provides sufficient area to route a cable bundle **300**, including ultrasound signal cables **304** and a laser cable **302**.

Referring now to FIG. 3, a cross section of the tool shaft **214** is illustrated to show a cable bundle **300** and drive cables **216** routed in the shaft. The cable bundle **300** is coaxially positioned near a center axis of the tool shaft **214**, and is routed through the tool shaft **214**, the wristed joint **218**, and into the end effector **220**. The cable bundle **300** includes a laser cable **302**, ultrasound cables **304** around the laser cable **302**, and a sheath **306** around the laser cable **302** and the ultrasound cables **304**.

The drive cables **216** that are routed through the shaft **214** are spaced apart from the cable bundle **300** and positioned near the inner circumference of the shaft **214**. As the drive cables **216** may move along the shaft **214**, they are spaced apart from the bundle **300** to try to avoid wear. The drive cables **216** may also be spaced from each other near the inner circumference of the shaft **214** as shown. The wristed joint **218**, shaft **214**, and end effector **202** may include cable

guides at their inner periphery to align and retain the position of the drive cables **216**. Retaining the drive cables **216** on the periphery allows end effector actuation cables (if any), electrical cables, ultrasound signal wires, and optical cables, to be routed down the center or lumen of shaft **214** and wristed joint **218** with less interference.

The laser cable **302** may be in the center of the cable bundle **300**, coaxially positioned near a center axis of the tool shaft **214**, and run the length of the tool from the housing **201A** at a proximal end to near an aperture in the end effector **220** at the distal end. In another embodiment of the invention, the laser cable **302** may further extend out from the proximal end of the tool **200A** and into the laser cable **106** to couple to the laser generator/controller **102A**, **102B**. In one embodiment of the invention, the laser cable **302** is a fiber optic cable, light pipe, or optical fiber to propagate the laser energy generated by a laser diode (e.g., laser diode **708** in FIG. 7A) or the laser controller/generator **102C** through the tool **200A**, **200B** to exit from an aperture in the end effector **220**. In another embodiment of the invention, the laser cable **302** is one or more electrical cables to power and control a laser diode (e.g., laser diode **608** in FIG. 6B) in the end effector **220** so that the laser energy is locally generated by the tool.

The ultrasound signal wires **304** in the bundle **300** near the laser cable **302** are numerous. The number of ultrasound signal wires **304** and relative size of the cables shown in FIG. 3 are for illustration purposes only. The actual number of ultrasound signal wires **304** within the cable bundle **300** depends upon the capabilities of the ultrasound probe and the number of ultrasound transducer elements. The greater the number of ultrasound transducer elements, the greater is the number of ultrasound signal wires **304** routed in the cable bundle **300**. The ultrasound signal wires **304** are insulated electrical cables for driving signals to excite the ultrasound transducer elements to generate the ultrasound waves and for receiving return signals back from the ultrasound transducer elements for coupling to an ultrasound controller/generator for signal processing.

In one embodiment of the invention, the ultrasound transducer **500** includes one hundred twenty eight (128) ultrasound transducer elements **504** arranged along the length of the ultrasound probe **500**. The acoustic window **510** may be one (1) transducer element wide and one-hundred-twenty-eight (128) transducer elements in length. In this case, the 128 transducers elements require 128 cables with two wires in each to drive them or more specifically, 256 conductors. Each transducer element typically has a pair of wires, a signal wire and a ground wire. The signal wire is for both transmitting and receiving ultrasound signals.

The sheath **306** is provided around the laser cable **302** and the ultrasound cables **304** to protect and bundle them together. The cable sheath **306** may comprise one or more segments of different material depending upon the location of the cable bundle within the tool. The one or more segments of the cable sheath **306** may be made of a flexible material or a rigid material. For example, the segment of the cable sheath **306** in the tool shaft **214** may be a rigid insulating plastic if the tool shaft itself is rigid. In contrast, the segment of the cable sheath **306** in the wristed joint is a flexible material. Otherwise, a rigid sheath may limit the movement of the end effector **202**. One of the purposes of the cable sheath **306** is to protect the ultrasound signal wires **304** and the laser cable **302** from contact with the drive cables **216**. Although the drive cables **216** may be routed through guide holes, slackening and tensioning of the drive

cables **216**, as well as movement of the bundle **300**, may result in inadvertent contact of the sheath **306** with the drive cables.

The cable sheath **306** may also facilitate the removal and replacement of the laser cable **302** contained therein. The cable sheath **306** may facilitate catherizing the laser cable **302** so that it may be removed and replaced in case of a malfunction. The cable sheath **306** may provide a guide for threading the laser cable **302** through the tool shaft **214** and the wristed joint **218** with minimal interference from the drive cables **216**.

Referring now to FIG. **4**, the cable bundle **300** is routed through the wristed joint **218** to the end effector **220**. The wristed joint seeks to emulate the dexterity of a surgeon's wrist in the tool **200A**, **200B**. The wristed joint **218** is used to manipulate the position of the combined laser imaging end effector **202** over at least two degrees of freedom. Other end effectors or working elements may be combined together and coupled to the wristed joint to perform robotic assisted surgery such as scissors, graspers, scalpels, or imaging devices such as high definition optical cameras and ultrasound probes. A wide range of motion in the wristed joint **218** is especially advantageous in a small surgical site to position the end effector **220** therein.

In one embodiment of the invention, the wristed joint **218** is a segmented wrist joint and includes a plurality of hollow disks or vertebrae **402-420** stacked or coupled in a series between the end effector **202** and the shaft **214**. A proximal vertebra **410** is coupled to the shaft **214**. A distal vertebra **402** couples to and supports the end effector **202**. The distal vertebra **402** may serve as a mounting base for various kinds of single-element and multi-element end effectors, such as scalpels, forceps, scissors, cautery tools, retractors, and the like. There is at least one intermediate or medial vertebra **404-408** disposed between the proximal vertebra **410** and the distal vertebra **402** to provide at least two degrees of freedom. Each disk or vertebrae **402-410** is configured to rotate in at least one degree of freedom with respect to each neighboring disk. In one embodiment of the wristed joint, a pair of tabs or segments **414** on opposite sides of the distal vertebra **402** and the intermediate vertebra **404-408** pivotally interface with a pair of slots **416** on opposite sides of the intermediate vertebra **404-408** and the proximal vertebra **410** for the wristed joint to pivot in a controlled manner.

A central lumen internal to the hollow disks or vertebrae **402-420** may serve as a conduit for fluid conduits (e.g., laser cooling, gas blower, irrigation, or suction), and the cable bundle **300**.

The plurality of drive cables **216** routed in the shaft **214** extend into the wristed joint **218**. The drive cables **216** may be one or more cable loops. One or more drive cables **216** may extend through the wristed joint **218** and into the end effector to actuate working elements. A distal portion of the drive cables **216** actuating the wristed joint **218**, are generally coupled to one or more of the plurality of hollow disks or vertebrae **402-420** to pivotally actuate the connected vertebra. A proximal portion of the drive cables **216** ends within the mountable housing **201A**, **201B** of the tool **200A**, **200B**. The proximal portion of drive cables **412** actuating the wristed joint **218** may generally be coupled to drive mechanisms within the mountable housing **201A**. The drive mechanisms within the mountable housing are configured to controllably move at least selected ones of the plurality of drive cables **216** to pivotally actuate the plurality of connected vertebrae **402-410** to bend the wrist member with respect to the shaft.

This and alternate embodiments of a segmented wrist joint for the wristed joint **218** are more fully described in U.S. Pat. No. 6,817,974 entitled SURGICAL TOOL HAVING POSITIVELY POSITIONABLE TENDON-ACTUATED MULTI-DISK WRIST JOINT filed by Thomas G. Cooper et al. on Jun. 28, 2002, which is incorporated herein by reference.

Referring now to FIGS. **3** and **4**, the cable bundle **300** is routed through the wristed joint **218** to the end effector **220**. The cable bundle **300** is positioned towards the center portion of the wristed joint **218** to avoid the vertebrae and drive cables **216** and to minimize bending of the cable bundle **300** therein. The cable sheath **306** of the cable bundle **300** further protects the ultrasound cables **304** and the laser cable **302** from the vertebrae of the wristed joint and the drive cables.

It may be preferable to retain the laser cable **302** near the center of the bundle **300**. In one embodiment of the invention, the laser cable **302** is an optical fiber. The placement of the cable bundle **300** near the center of wristed joint **218** may limit damage to an optical fiber by insulating it in several layers of cables **304** and the sheath **306**. If an optical fiber is overly bent greater than a predetermined angle, the optical signal within the cable may refract and escape through the fiber cladding thereby lowering the laser energy that may be propagated therein. Excessive bending may also permanently damage an optical fiber by causing micro cracks therein that may compromise light transmission. This may result in bend loss in an optical fiber such that there is a loss of signal strength from one end of the fiber to the other. The center of the shaft and wristed joint may experience less bending than the periphery. Thus, placement of the laser cable **302** near the center of the cable bundle may subject an optical fiber to less bending relative to the outer circumference of the wristed joint **218**. Retaining the optical fiber near the center of the wristed joint and cable bundle **300** insulated by the outer layers of cables, wires, and sheathing surrounding it, may help limit the bending and shock an optical fiber may experience. To ease replacement in the case of damage, the laser cable **302** may have its own sheath or conduit **303** into which the cable may be removed and inserted for replacement purposes.

Referring now to FIGS. **5A-5C**, views of alternate embodiments **220A-220C** of the combined laser ultrasound imaging end effector **220** are illustrated. Each of the embodiments of the combined laser ultrasound imaging end effectors **220A-220C** includes an ultrasound probe **500** to provide ultrasound images and facilitate laser marking/cutting by laser. Each of the end effectors **220A-220C** couples to the wristed joint **218** and includes a case, housing, or enclosure **502**; a plurality of ultrasound transducer elements **504** forming the ultrasound probe **500**; and an opening or aperture **506** from which laser light may exit for marking or cutting. The laser cable **302** from the wristed joint **218** is routed towards the laser aperture **506** in each. The ultrasound cables **304** from the wristed joint **218** are routed and coupled to some of the plurality of ultrasound transducer elements **504** of the ultrasound probe **500**.

The laser aperture **506** may be located in different positions as illustrated by the embodiments of the combined laser ultrasound imaging end effectors **220A-220C** of FIGS. **5A-5C**, respectively, so as to minimize interference with the ultrasound acoustics of the ultrasound transducer elements **504**. For example, in FIG. **5A**, the laser aperture **506** is longitudinally positioned near a mid region of the ultrasound probe **500** and the edge of the enclosure **502** so as to avoid a break in the ultrasound transducer elements. In FIG. **5B**,

the laser aperture **506** is positioned near a distal end of the ultrasound probe **500** and a center of the enclosure **502**. In FIG. **5C**, the laser aperture **506** is positioned near a proximal end of the ultrasound probe **500** and a center of the enclosure **502**.

The enclosure **502** is a protective case surrounding the plurality of ultrasound transducer elements **504** of the ultrasound probe **500**. The enclosure **502** may be hermetically sealed so that body fluids such as gastric juices, blood, bile, etc. are not trapped in its interior. This is so the tool **200A**, **200B** may be readily sterilized for repeated use in different robotically assisted surgeries of different patients. The enclosure **502** can also protect the ultrasound probe **500** during sterilization procedures.

The enclosure **502** is typically formed of an acoustically appropriate material to provide an acoustic lens or window **510** for the ultrasound transducer elements **504** of the ultrasound probe **500**. A separate acoustic lens or window **510** over the ultrasound transducer elements **504** may be hermetically sealed to the housing. In which case, the enclosure **502** may be made of a different material that is not as acoustically appropriate as the window **510**. In one embodiment of the invention, the non-acoustic portions of the housing or enclosure **502** are formed of ULTEM 1000 polyetherimide (generally, an amorphous polymer or plastic) made by General Electric Company, for example, while the acoustic lens or window **510** is formed out of an acoustically acceptable material, such as a silicone room temperature vulcanizing (RTV) compound made by Dow-Corning, for example. Alternatively, the entire housing or enclosure **502** may be made of the same material as the acoustic lens or window **510**. For injection molding of the casing and lens as one-piece, it may be desirable to cast the entire enclosure **502** out of silicone room temperature vulcanizing (RTV) compound. When using a casing material having non-acoustic properties, the ultrasound lens or window **510** can be formed separately from other suitable acoustic materials, such as polyurethanes for example.

The internal structure of the enclosure **502** may be formed of a rigid material. Because autoclaving is an often used disinfecting/sterilization method the deformation temperature of the internal structures should also exceed the 249 degrees Fahrenheit of typical autoclave procedures. By way of example, metals such as aluminum, stainless steel, brass, or even structural plastic may be used. The internal structure of the enclosure **502** may have receptacles to receive the array of ultrasound transducers **504**, as well as channels in which the laser cable **302** and ultrasound signal wires **304** may be routed from the wristed joint **218**.

The ultrasound probe **500** transmits acoustic energy into body tissue within a surgical site and converts the return signal into an electrical signal. The ultrasound transducer elements **504** of the ultrasound probe **500** transmit an acoustic signal into the body tissue of a patient. The signal bends when it encounters the interfaces between different structures, i.e. when it encounters material with a different acoustic impedance, and is reflected back. The reflected signal is received by the ultrasound transducer elements **504** and processed into an image of the surgical site.

The intensity of the return signal and the time it takes to receive the signal may be plotted by a computer processor to produce a two dimensional image of the area scanned by the ultrasound probe **500**. Generally the closer the probe **500** is to the tissue or organ being scanned, the better the resolution of the ultrasound image. To produce three-dimensional images with the ultrasound probe **500**, multiple arrays of transducers **504** are used or alternatively the probe **500** may

be rotated or moved around to scan tissue or organs from different positions to generate multiple images. The multiple images may then be combined together and interpolated by computer software to display three-dimensional images.

The transducer elements **504** comprise piezoelectric ceramic elements. In order to resonate the piezoelectric ceramic element and receive a return signal, each is electrically connected to a signal source and ground. The transducer elements **504** may be arranged into a one-dimensional array or a multi-dimensional array.

The series of piezoelectric ceramic elements, which make up transducer elements **504**, may be formed out of a single piece of ceramic material. A break in the series of transducer elements **504** to incorporate the laser aperture **506** may be impractical. Furthermore, a laser aperture **506** placed amongst the transducer elements **504** may distort the return signal. By positioning the laser aperture **506** to the side or the ends of the ultrasound probe **500** without breaking up the transducer elements **504**, problems may be alleviated or avoided. Thus, the position of the laser aperture **506** is made outside the ultrasound probe **500** in FIGS. **5A-5C** to try to minimize interference with the ultrasound signals.

Further description of the transducer elements **504** and their formation into the ultrasound probe **500** may be found in U.S. Pat. No. 6,088,894 entitled METHODS OF MAKING COMPOSITE ULTRASONIC TRANSDUCERS issued on Jul. 18, 2000 to inventors Oakley et al., which is incorporated herein by reference.

Referring now to FIGS. **6A-6B**, alternate embodiments of transmission and generation of laser energy in the end effector **220** are illustrated. The laser cable **302** in the cable bundle **300** may be an optical fiber **302A** as shown in FIG. **6A** or one or more electrical cables **302B** as shown in FIG. **6B**. In either case, photons of a laser light **600** may exit out from the aperture **506** in the enclosure **502**. The position of the aperture **506** in the end effector is chose to minimize interference to the individual piezoelectric transducer elements **504** that are stacked in series to form the ultrasound probe **500**.

The end effector **220** may have a lens or a transparent cover **602** mounted and hermetically sealed into the aperture **506**. The lens or transparent cover **602** may provide additional collimation or focusing of the laser light. Alternatively, a separate collimating or focusing lens **604A**, **604B** may be provided under the transparent cover **602** to further collimate or focus the laser light prior to it exiting out from the end effector though the aperture **506**. The transparent cover **602** and lens **604A**, **604B** are aligned with the optical axis **610** of the laser light **600**.

The transparent cover **602** may be flat-shaped and level with the surface of the ultrasound probe enclosure **502** to be cleaned more easily and thoroughly than a curved lens. The transparent cover **602** may be made of a scratch resistant transparent plastic, fiberglass, glass, crystal, or Plexiglas material suitable for transmitting the wavelength of the laser light through it. The transparent cover **602** may be hermetically sealed to the enclosure **502** of the end effector to avoid the intrusion of contaminants into ultrasound probe **500**. With a hermetic seal around the transparent cover, liquid and gaseous disinfectants that may be used to clean the end effector after surgery is prevented from entering the enclosure **502** and damaging the piezoelectric elements and electrical connections made therein. If scratched or otherwise damaged the transparent cover **602** may easier to replace than a curved lens **604A**, **604B**.

Light emitted from the distal end **605** of fiber **302A** diverges in angle, by an amount determined by the angular

spread of the light entering the proximal end of the fiber. In order to couple the laser light into the smallest possible fiber core, the laser source may use focusing optics to couple the light, which results in a significant angular divergence of the entering beam, and therefore of the exiting beam as well. In addition, laser light traveling through the insufflating gas used in laparoscopic surgery may excite the gas and cause it to act as a defocusing lens. When a laser is defocused the diameter of the laser dot increases without a corresponding increase in the power, thus causing a loss of power density. This blooming effect may cause the laser to char and coagulate instead of cutting tissue as desired. To maintain the highest possible power density at the outer surface of transparent window or cover **602**, which with an ultrasound instrument is in contact with the tissue, a converging lens or lens system may be used, illustrated schematically in FIG. **6A** by a single plano-convex lens **604A**.

In FIG. **6A**, laser energy generated by an external laser generator (e.g., laser controller generator **102C** of FIG. **1A**) or a remote internal laser diode (e.g., laser diode **708** of FIG. **7A**) travels down the optical fiber **302A** and is launched out the end of the optical fiber **302A** parallel to the optical axis **610**. The collimating lens **604A** may also collimate the laser light launched out of the end of the optical fiber **302A** so it is substantially parallel to the optical axis **610**. The collimated laser light may exit out of the end effector through the transparent cover **602** and onto targeted tissue in a patient's body.

The optical fiber **302A** may be a flexible fiber optic cable for carbon-dioxide (CO₂) lasers produced by OMNIGUIDE, for example, if a CO₂ laser is used in the laser controller/generator.

In FIG. **6B**, the end effector **220D** includes a laser diode **608** coupled to a printed circuit board (PCB) **609** that is mounted in the housing under the aperture **506**. The one or more electrical cables **302B** couple to the printed circuit board **609** in electrical communication with the laser diode **608**. The active region of the laser diode **608** is centered in alignment with the optical axis **600** under the cover **602** and the lens **604B**. In this case, the laser energy is locally generated by the tool to ease the cable connections to the tool.

The laser diode is excited by power and signals from the electrical cables **302B** to generate photons of sufficient energy to exit the active region of the laser diode. The photons or laser light from the laser diode, being somewhat parallel to the optical axis **610** but still diverging from the emitting area of the laser diode, is coupled into the lens **604B**. The focusing lens **604B** may collimate the laser light launched out of the laser diode so it is substantially parallel to the optical axis **610**, or focus it at a desired distance from the lens **604B**, to control the location along the optical axis **610** where the maximum power density is attained. The collimated laser light may exit out of the end effector **220D** through the transparent cover **602** and onto targeted tissue in a patient's body.

If the laser diode **608** is being used to mark tissue at lower laser power levels, cooling the laser diode may be unnecessary. However, if the laser diode is being used to cut or ablate tissue at higher power levels, cooling the laser diode may be useful. If so, a heat sink (not shown) may be thermally coupled to the laser diode to draw heat away from it. Alternatively, a liquid cooling may be provided from an auxiliary channel (not shown) by flowing an irrigating liquid (e.g., sterile water or saline) pass the laser diode **608** and out of the tool to provide irrigation in the surgical site and perhaps a backstop to the laser light. The heat transfer may

be by convection or by directly leaking some of the irrigating liquid around the laser diode avoiding obscuring the surgical site but sufficient to cool the laser.

Referring now to FIG. **7A**, the mountable housing **201A** of the tool **200A** is illustrated with its cover **202A** removed to show the internal drive mechanisms and cable connections. The mountable housing **201A** includes a gimbaled cable actuator **700** to manipulate the cables to control movement of the wristed joint **218**. The actuator **700** includes a rocker or actuator plate **702** mounted in a gimbaled configuration. The actuator plate **702** pivotally coupled to a parallel linkage **740**. An articulated parallel strut/ball joint assembly is employed to provide a gimbaled support for the actuator plate **702**. This allows the actuator plate **702** to tilt in two degrees of freedom.

The proximal ends of the drive cables **216** are coupled to the actuator plate **702** to control the movement of the wristed joint **218**. Apertures on the actuator plate **702** receive the proximal end of the drive cables **216** that extend to the disks or vertebrae of the wristed joint **218**.

The actuator **700** further includes a first actuator link **704** and a second actuator link **706** are rotatably coupled near one end to the actuator plate **702** through ball joint mechanisms. The actuator plate **702** is moved by the first actuator link **704** and the second actuator link **706** to produce pitch and yaw rotations in the wristed joint **218**.

The actuator **700** further includes a first follower gear quadrant **714** and a second follower gear quadrant **716** pivotally coupled to the mountable base **204** at pivot points **734** and **736**, respectively. The first follower gear quadrant **714** is pivotally coupled to the first actuator link **704** near its second end by a pivot joint **718**. The second follower gear quadrant **716** is pivotally coupled to the second actuator link **706** near its second end by a pivot joint **720**.

The actuator **700** further includes a first drive gear **724** and a second drive gear **726** geared to the first follower gear quadrant **714** and a second follower gear quadrant **716**. Each of the first drive gear **724** and the second drive gear **726** are coupled to a first end of a rotatable drive shaft **740** extending through the mountable base **204**. A rotatable receiver **742** is coupled to the opposite end of each rotatable drive shaft **740**. Each rotatable receiver **742** of the tool mates with a rotatable driver of the robotic surgical arm when mounted thereto.

As the rotatable receivers **742** are driven by a rotatable driver of the robotic surgical arm, the drive gears **724, 726** rotate to respectively pivot the first and second follower gear quadrants **714, 716** about their respective pivot points **734, 736**. As the first and second follower gear quadrants **714, 716** rotate about their respective pivot points **734, 736**, the actuator links **704, 706** coupled by the joints **718, 720** to the gear quadrants are driven to generally move longitudinally and pivot the actuator plate **702** and move the drive cables **216**.

FIG. **7A** illustrates the actuator plate **702** of the gimbaled cable actuator **700** in a pitch rotation by both actuator links **704, 706** moving together in parallel. A mixture of pitch and yaw rotations in the actuator plate **700** is the result of mixed movement in the actuator links **704, 706** in response to the corresponding rotation of the rotatable receivers **742**, rotatable drive shafts **740**, and gears **724, 726**.

The cable actuator **700** is described in further detail in U.S. Pat. No. 6,817,974 entitled SURGICAL TOOL HAVING POSITIVELY POSITIONABLE TENDON-ACTUATED MULTI-DISK WRIST JOINT filed by Thomas G. Cooper et al. on Jun. 28, 2002, which is incorporated herein by reference.

However, alternative embodiments of the pivoted-plate cable actuator mechanism having aspects of the invention may have different structures and arrangements for supporting and controllably moving the actuator plate **702**. For example the plate may be supported and moved by various types of mechanisms and articulated linkages to permit at least tilting motion in two DOF, for example a Stewart platform and the like. The plate assembly may be controllably actuated by a variety of alternative drive mechanisms, such as motor-driven linkages, hydraulic actuators; electro-mechanical actuators, linear motors, magnetically coupled drives and the like.

In one embodiment of the invention, an optical fiber **302A** is routed from the aperture **506** at the end effector through the tool **200A** into the cable **106** to the connector **210A** as shown in FIGS. **2A**, **3**, **4**, **5A**, **6A**, and **7A**. In this case, an external laser generator/controller (e.g., laser generator/controller **102A** of FIG. **1A**) is used to generate the laser light.

In another embodiment of the invention, an optical fiber **302A** is routed from the aperture **506** at the end effector **202** through the shaft **214** and to a laser diode **708** coupled to a printed circuit board **709** mounted in the housing **201A**. An end of electrical laser cables **302B'** are coupled to the printed circuit board **709** in communication with the laser diode **708**. The electrical laser cables **302B'** are routed in the laser cable **106** and couple to the connector **210A**. Instead of generating the laser light, the laser generator/controller **102A** generates control signals in the electrical laser cables **302B'** to control the local generation of laser light by the laser diode **708**. The laser light generated by the laser diode **708** is coupled into the optical fiber **302A'** to route the laser light through the tool to the aperture **506** in the end effector **220**.

Referring now to FIG. **2B**, an alternate embodiment of a combined laser imaging tool **200B** is illustrated. The combined laser imaging tool **200B** is similar to the combined laser imaging tool **200A** but generally differs in the mountable housing **201B** and how a laser cable **106** and an ultrasound cable **108** couple there-to. The laser cable **106** provides a means for routing signals from a laser generator/controller to the robotic surgical tool **200B**. The ultrasound cable **108** provides a means for routing signals from an ultrasound generator/controller to the robotic surgical tool **200B**. With the combined laser imaging tool **200B**, the laser cable **106** and the ultrasound cable **108** are readily detachable from the tool. This may be advantageous to ease sterilizing the tool or to more quickly make equipment changes.

Referring for the moment to FIG. **2A**, a first laser cable connector **210A** is coupled to a first end of the laser cable **106** as shown. The first connector **210A** is used to connect the laser cable **106** to a laser generator/controller. Referring now to back FIG. **2B**, a second laser cable connector **210B** is coupled to the second end of the laser cable **106**. To connect the laser cable **106** to the tool **200B**, the second connector **210B** quickly couples to a laser cable receptacle **226**. The second connector **210B** may also be quickly detached from the receptacle **226**. The first and second connectors **210A-210B** may be male bayonet Neill-Concelman (BNC) connectors and the receptacle **226** may be a female BNC connector. If a surgeon decides a different robotic surgical tool is needed in place of the tool **200B**, the cable **106** can be quickly detached to more quickly make a tool change.

Referring for the moment to FIG. **2A**, a first ultrasound connector **212** is coupled to a first end of the ultrasound cable **108** as shown. The first connector **212** is used to

connect the ultrasound cable **108** to an ultrasound generator/controller. Referring now to back FIG. **2B**, a second ultrasound connector **222** is coupled to the second end of the ultrasound cable **108**. To connect the ultrasound cable **108** to the tool **200B**, the second connector **222** quickly couples to an ultrasound receptacle **224**. The connector **222** may be a male electrical pin connector while the receptacle **224** is a female electrical pin connector. The second connector **222** may be quickly detached from the receptacle **224**. If a surgeon decides a different robotic surgical tool is needed in place of the tool **200B**, the cable **108** can be quickly detached to more quickly make the tool change.

The ultrasound wires **304** coupled to the ultrasound transducers **504** may couple to the receptacle **224**. However, with the electrical connector **222** and receptacle **224**, the pin and wire count in the ultrasound cable **108** may be reduced to avoid large pin counts and avoid routing so many wires between connectors **212** and **222**. In this case, a plurality of ultrasound signals may be serialized or multiplexed onto one signal wire of the ultrasound cable **108**.

Referring now to FIG. **7B**, the mountable housing **201B** of the tool **200B** is illustrated with its cover **202B** removed to show the internal drive mechanisms and cable connections. The mountable housing **201B** is similar to the mountable housing **201A** but for how the laser cable **106** and the ultrasound cable **108** are coupled there-to.

The mountable housing **201B** includes the gimbaled cable actuator **700** previously described herein to manipulate the driver cables **216** to control movement of the wristed joint **218**. The description of the gimbaled cable actuator **700** is incorporated here by reference to avoid duplicity.

The mountable housing **201B** further includes the ultrasound cable receptacle **224** and the laser cable receptacle **226** mounted to the base **204** and/or the cover **202B**. The mountable housing **201B** may further include an isolation chamber **203B** under the cover **202B** to isolate a printed circuit board **750**, the electrical connections, and electrical cables from the drive mechanisms or transmission for the drive cables **216**.

As previously mentioned, a plurality of ultrasound signals may be serialized or multiplexed onto one signal wire of the ultrasound cable **108**. The ultrasound connector **222** couples to the ultrasound receptacle **224** to couple power/signal wires of the ultrasound cable **108** to the power/signal wires **756**. The power/signal wires **756** couple to the printed circuit board **750**. The printed circuit board **750** includes an ultrasound signal combiner **752** and an ultrasound voltage generator **754** coupled together. The signal wires couple to the ultrasound signal combiner **752**. The power wires couple to the ultrasound voltage generator **754**.

The signal combiner acts as a multiplexer/demultiplexer and/or serializer/deserializer to combine a plurality of signals from the ultrasound sensors together for communication over fewer parallel wires to the external ultrasound generator/controller. This allows the pin count of the ultrasound connector **222** and the ultrasound receptacle **224** to be less so they are smaller connectors. Additionally, there are fewer wires routed in the ultrasound cable **108**.

An end of the ultrasound signal wires **304** are coupled to the printed circuit board **750** and the signal combiner **752** and/or voltage generator **754**. The ultrasound signal wires **304**, as part of the cable bundle **300**, are routed through a center opening in the actuator plate **702**, through a hollow center of the parallel linkage **740**, and into the shaft **214** of the tool.

The ultrasound transducers **504** are excited by high voltages to generate ultrasound signals. Instead of generating

high voltage signals at an external ultrasound generator/controller, it may be more convenient to locally generate the high voltage signals to excite the ultrasound transducers **504**. In response to control signals from the signal combiner **752**, the ultrasound voltage generator **754** generates a plurality of high voltage signals for exciting the ultrasound transducers **504** to generate the ultrasound signals.

The laser cable receptacle **226** couples to an end of the laser cable **302**. The laser cable **302** may be an optical fiber **302A** to propagate laser light to the end effector **220A** or electrical control wires **302B** to power and signal a laser diode **608** in the end effector **220D**. In either case, the laser cable **302**, as part of the cable bundle **300**, is routed through the center opening in the actuator plate **702**, through the hollow center of the parallel linkage **740**, and into the shaft **214** of the tool for routing to the end effector.

If the laser cable **302** is an optical fiber **302A**, the use of the connector **210B** and the receptacle **226** may allow it to be readily replaced if damaged or defective to repair the tool. Optical fibers are susceptible to heat damage from excess laser energy as well shock damage from misuse. Optical fibers may also acquire microscopic cracks or breaks if they exceed their maximum radial bend. Once heat damaged or cracked, the optical fiber may not transmit laser energy as efficiently, resulting in decreased laser energy at the working end. If the laser cable **106** is damaged or defective, the use of the connector **210B** and the receptacle **226** may allow it to be readily replaced if damaged or defective.

Operation of the Combined Ultrasound-Laser Tool

Referring now to FIG. **8**, an illustration depicts an image **800** of the surgical site and the ultrasound picture in picture images that may be displayed in the viewer of the surgeon's console. A two-dimensional or three-dimensional image is displayed on a video screen for the surgeon performing the procedure. Ultrasound images **811B-811D** are combined and interpolated by a computer processor into a combined ultrasound image **811A**. A targeting dot **822** may be displayed on combined ultrasound image **811A** to represent the location where the laser is focused. In one embodiment of the invention, the targeting dot **822** is a computer-generated dot (such as generated by the computer **151A**, **151B**) that appears only on the display monitor and is not a physical mark in the surgical site.

The targeting dot **822** may be used by the surgeon to aim the marking laser in an ultrasound image. For instance, as mentioned previously, ultrasounds may be used to differentiate healthy cells from cancerous cells. Once masses of cancerous cells are identified on the ultrasound image, a surgeon may begin marking the boundaries of the cancerous cells for later removal. A marking laser may be used to burn a series of dots delineating the boundaries of the cancerous mass. The burn marks would not likely show up on an ultrasound image, so in order to aid the surgeon, a virtual display of the burn marks may be created with some specialized software. Each time the laser is fired a virtual dot may be displayed on the video monitor. In this way, the surgeon may be better able to track their progress as they mark the area to be excised. Once the area is marked, the ultrasound images may be removed from the video monitor displaying video images of the surgical site. The burn marks should be optically visible by the camera and shown in the video display to provide the surgeon with an accurate map of the area to be excised.

In another embodiment of the invention, a cutting laser such as a CO₂ laser may be deployed at the ultrasound probe. Once again, the targeting dot **822** may be used by the surgeon to guide the laser cutter. A virtual image of the cut

line may be created by software and superimposed on ultrasound image **811A** to aid the surgeon in guiding the laser.

Referring now to FIG. **9**, an image of the surgical site **900** is illustrated after laser marking has been completed. The dotted line **902** represents burn marks made on tissue by a laser that was guided by ultrasound imagery. The laser marked tissue can reduce the time spent looking for tissue that requires surgery. Robotic surgical tools **910L** and **910R**, such as robotic surgical scissors, may be readily moved into the marked area to perform surgery therein.

The added functionality provided by a combined laser/imaging tool may improve the efficiency of a surgeon and thereby lower the costs of minimally invasive surgical procedures. With a four arm robotic surgical system or the like, an endoscopic camera tool and an ultrasound imaging tool with lasers are available while a surgeon performs surgery with his left and right hands controlling tissue manipulative robotic surgical tools (e.g., monopolar scissor, and a bipolar grasper). With the laser/ultrasound combination, a surgeon may have three types of energy (monopolar, bipolar, and laser) to apply to tissue, two imaging capabilities (camera and ultrasound, with picture in picture) and two mechanical tools (cutting and grasping) for combined seven tools using only four robotic surgical arms.

Robotically Controlled Endoscopic Camera with Laser Cutting Tool

To perform minimally invasive surgery in areas around the neck and throat, a robotic surgical system that can use the openings provided by the nose or throat may be preferable. However, this limits the number of openings through which robotic surgical tools may be inserted. The robotic surgical tools are made smaller so that a plurality of robotic surgical tools may pass through a single opening. To gain even more surgical capability through the one opening, the robotic surgical tools may be multitasking in their capabilities.

Previously described herein was a combined ultrasound-laser robotic surgical tool. A combined laser-endoscopic camera robotic surgical tool is now described to provide multiple surgical capabilities in one robotic surgical tool.

Referring now to FIG. **10**, a portion of a patient side cart **1052** is illustrated with an actuating end **1016** of a robotic or manipulating arm **1014**. But for a single robotic arm **1014**, other portions of the patient side cart **1052** may be similar to the patient side cart **252** illustrated in FIG. **1B** to support the actuating end **1016** over a patient **P**. The robotic arm **1014** may be coupled to a set-up arm. The robotic surgical system including the patient side cart **1052** may be similar to the robotic surgical systems illustrated in FIGS. **1A** and **1C** including the one or more control consoles and the laser/generator controller.

The general function of the actuating end **1016** of the robotic or manipulating arm **1014** and the robotic surgical tools coupled thereto are described in more detail in U.S. patent application Ser. No. 11/762,165 entitled MINIMALLY INVASIVE SURGICAL SYSTEM filed by Larkin et al. on Jun. 12, 2007 which is incorporated herein by reference.

A single guide tube **1008** of the actuating end **1016** of the robotic arm is used to insert the tools **1002A**, **1002B**, and **1018** into an opening into the patient **P**, such as the patient's mouth for example. The guide tube **1008** is coupled to the platform **1012** which is in turn moveably coupled to the robotic arm **1014** by one or more actuator mechanisms for pitch, yaw, roll, and insertion along an insertion axis of the guide tube. The guide tube **1008** may be maintained in a fixed position or rotated (e.g., pitch, yaw, and/or roll) around

a remote center point **1020** near the opening into the patient if permitted by the circumstances, including the tissue in the body where the tools may be located.

The robotic surgical tool **1018** that is more fully inserted into the guide tube **1008** is a combined laser ablation-imaging robotic surgical tool to provide multiple capabilities in one instrument. The two other robotic surgical tools **1002A-1002B** are illustrated as being partially inserted into the guide tube **1008** in FIG. 10. The robotic surgical tools **1002A-1002B** may be different types of robotic surgical tools than the combined laser ablation-imaging robotic surgical tool **1018**. The combined laser ablation-imaging robotic surgical tool **1018** efficiently uses the available opening provided by the singular guide tube **1008**.

Referring now to FIG. 11, a proximal end of the robotic surgical tools **1018**, **1002A-1002B** are shown inserted into the guide tube **1008** and coupled to a tool actuator assembly **1004**. Each tool **1018**, **1002A**, **1002B** may include a body tube **1006** inserted into the guide tube **1008**. The tool actuator assembly **1004** is mounted to a linear actuator **1010** (e.g., a servo-controlled lead screw and nut, or a ball screw and nut assembly) that independently controls each tool's further insertion within guide tube **1008** along with its body tube's **1006**. The guide tube **1008** may be removeably mounted to the support platform **1012**. Removable and replaceable guide tubes allow different guide tubes designed for use with different procedures to be used with the same telemanipulative system (e.g., guide tubes with different cross-sectional shapes or various numbers and shapes of working and auxiliary channels).

The actuator assembly **1004** mates with and actuates components in the robotic surgical tools **1018**, **1002A-1002B**. The actuator assembly **1004** includes a plurality of rotatable servomotor actuators **1126** coupled to actuator disks **1122**. Each actuator disk **1122** includes holes to interface to pins of rotatable interface disks of the robotic surgical tools. Each actuator disk **1122** is rotated in response to servo control inputs to control the robotic surgical tool.

Referring now to FIG. 12, a distal end of the robotic surgical tools **1018**, **1002A-1002B** is shown extending out from the guide tube **1008**. The guide tube **1008** includes a channel **1218** and a pair of channels **1202** through which the respective robotic surgical tools **1018** and **1002A-1002B** may be inserted and extend. The guide tube **1008** may further include an auxiliary channel **1260** through which other robotic surgical tools may be introduced or withdrawn, such as irrigation, suction, or cleaning devices for example. As illustrated in FIG. 12, the body tube **1006** of each respective robotic surgical tool **1018**, **1002A-1002B** may extend out from the respective channels of the guide tube **1008**. With the guide tube **1008** entering natural orifices of a body, its diameter and the diameter of each respective robotic surgical tool **1018**, **1002A-1002B** is limited. By providing more than one capability to a robotic surgical tool, the limited diameter of the guide tube is more efficiently utilized. Moreover, a tool change may be reduced or eliminated by combining more than one capability into a robotic surgical tool.

Each of the respective robotic surgical tools **1002A-1002B** include end effectors **1248A-1248B** coupled to the body tube **1006** by one or more joints **1244A-1244B**, **1246A-1246B**, and a parallel tube **1245A-1245B**. In one instance, the body tube **1006** for the robotic surgical tools **1002A-1002B** is approximately 7 mm in diameter. In another instance, the body tube **1006** for the robotic surgical tools **1002A-1002B** is approximately 5 mm in diameter.

The combined laser ablation-imaging robotic surgical tool **1018** is now described in more detail.

Referring now to FIG. 13, a perspective view of the combined laser ablation-imaging robotic surgical tool **1018** is illustrated. The combined laser ablation-imaging robotic surgical tool **1018** includes a housing **1301** with a mountable base **1304**, a transmission mechanism **1303**, a shaft or body tube **1006**, and an end effector **1348** coupled together. The housing **1301** and the transmission mechanism **1303** are coupled to the proximal end of the body tube **1006** while the end effector **1348** is coupled to the distal end of the body tube **1006**. The end effectors **1348** may couple to the body tube **1006** by one or more joints **1344**, **1346**, and a parallel tube **1345**. The one or more joints may be wristed joints, such as the segmented wristed joint described previously with reference to FIG. 4. The shaft or body tube **1006** for the combined laser ablation-imaging robotic surgical tool **1018** may or may not be cylindrically shaped.

The transmission mechanism **1303** provides a mechanical interface for the tool and includes a plurality of rotatable interface disks **1310**. One or more the rotatable interface disks **1310** are associated with a degree of freedom of the combined laser ablation-imaging robotic surgical tool **1018**. For example, a rotatable interface disk **1310** may be associated with instrument body roll degree of freedom illustrated by the doubled-headed arrow **1316**. The rotatable interface disks **1310** may be arranged for compactness, such as the triangular shape as shown for example. Each rotatable interface disk **1310** includes a pair of spaced apart raised pins **1312**. The raised pins **1312** of each rotatable interface disk may be spaced eccentrically to provide proper disk orientation when mated with an associated actuator disk.

The transmission mechanism **1303** includes a plurality of mechanical components (e.g., gears, levers, gimbals, cables, etc.) to convert roll torques **1320** received by the rotatable interface disks **1310** and transmit the torque into movement of the components of the combined laser ablation-imaging robotic surgical tool **1018**, such as roll **1316** in the body tube **1006** or pitch in the end effector **1348**, for example. One or more cables, cable loops, hypotubes, and/or any combination thereof within the body tube may be used to transfer the torque received by the transmission mechanism **1303** to the components at the distal end of the tool, such as the pitch movement of the end effector **1348**.

The housing **1301** includes one or more electronic interface connectors **1314** to provide an electronic interface for the combined laser ablation-imaging robotic surgical tool **1018**. One or more of the electronic interface connectors **1314** are used to interface to one or more cameras in the end effector **1348**.

One or more of the electronic interface connectors **1314** may be used to pass information stored in a semiconductor memory integrated circuit to the master control console regarding the tool and its end effectors. Such passed information may include instrument type identification, number of instrument uses, and the like. The control system may be used to update the stored information (e.g., to record number of uses to determine routine maintenance scheduling or to prevent using an instrument after a prescribed number of times).

One or more of the electronic interface connectors **1314** may be used to connect to a power supply or a laser generator to provide power for electronics in the tool, such as a laser diode. Alternately, a power connection may be positioned elsewhere in the housing **1301** on the tool **1018**.

Other connectors for, e.g., optical fiber lasers, optical fiber distal bend or force sensors, irrigation, suction, etc. may be part of the housing **1301**.

One or more of the electronic interface connectors **1314** may also be used to interface to a laser diode in the end effector **1348** in one embodiment of the invention. The electronic interface connector **1314** can couple electrical cables together so that the laser diode can couple to a laser controller **102B** to control the laser diode.

In another embodiment of the invention, the housing may include a receptacle **226**, such as a BNC receptacle **226**, coupled to a fiber optic cable leading to an end of the end effector **1348**. A BNC connector **210** connects to the BNC receptacle **226** to couple fiber optic cables together to route laser energy from a laser generator **102B** into a fiber optic cable **1326** within the tool. The fiber optic cable **1326** routes the received laser energy through the tool to the end of the end effector **1348**. Depending upon the life expectancy of the overall tool and fiber optic cable **1326** used for lasing, the cable **1326** may be readily replaceable. If the expected life expectancy of the fiber optic cable **1326** exceeds that of the overall tool, the cable **1326** may not need to be easily replaceable and be more integrated into the tool to lower costs. On the other hand, if the expected life expectancy of the fiber optic cable **1326** were only one surgery, it would be designed to be readily replaceable. Other fiber optic cables (see FIGS. **14A-15A**) may be used to transmit lower light energy to provide lighting within a body cavity for the one or more cameras in the tool **1018** to capture video images. End Effector for Image Capture and Laser Cutting

FIGS. **14A-14B** and **15A-15B** respectively illustrate alternate embodiments of the end effector **1348** (end effectors **1348A**, **1348B**) of the combined laser ablation-imaging robotic surgical tool **1018**.

Referring now to FIG. **14A-15A**, the combined laser ablation-imaging robotic surgical tool **1018** includes a fiber optic bundle **1400** terminating at the end effector **1348A**, and one or more cameras **1402A-1402B**. The fiber optic bundle **1400** includes the fiber optic cable **1326** within a channel **1426**, and a plurality of light pipes or fiber optic cables **1436** bundled together around the channel **1426** by a sheath **1446**. Alternatively, the plurality of light pipes or fiber optic cables **1436** may be bundled together and routed through separate channels within the tool **1018**. Light for the plurality of light pipes or fiber optic cables **1436** may be generated by one or more light emitting diodes (LED) in the tool such as to the diode **708** illustrated in FIG. **7A**, or alternatively generated by an external illuminator such as a Xenon short-arc lamp, or by other well-known means. Alternatively, one or more light emitting diodes (LED) may be included as part of the end effector, space permitting, instead of the using the plurality of light pipes or fiber optic cables **1436**.

The fiber optic cable **1326** can carry sufficient laser energy from the laser generator **102B** to laser cut or ablate tissue. The laser energy from the laser generator **102B**, transmitted in the fiber optic cable **1326** and coupled to tissue, may be less in order to mark the tissue in the body. That is, the laser energy may be selected for laser marking of tissue. A focusing lens or lens system **1427A** may be located between the distal end of the fiber optic cable **1326** and the inside surface of the transparent cover or window **1481A**, and functions to collimate the laser light diverging from the fiber optic cable **1326**, or to focus it in order to attain maximum energy density at a desired distance from the external surface of the transparent cover or window **1481A**. The channel **1426** may facilitate the replacement of the fiber optic cable **1326** if the need arises. The number of light pipes or fiber

optic cables **1436** in the tool **1018** is such that if a couple fail, the lighting supplied by those still functioning is sufficient for the one or more cameras to continue capturing images. The cameras sensitivity may also be able to compensate for some loss of lighting due to the failed light pipes or fiber optic cables **1436**.

The one or more cameras **1402A-1402B** each include an image sensor **1451** (e.g., charge coupled device array), one or more lenses **1452A-1452B**, and a transparent cover **1461** aligned together along an optical axis **1460** by a housing **1462**. The image sensor **1451** captures images from light passing through the transparent cover. The one or more lenses **1452A-1452B** capture light from the objects in the surgical field, and focus it into the image sensor **1451**. The transparent cover **1461** may be hermetically sealed to the camera housing **1462** and/or the end effector enclosure **1465**.

Each of the one or more cameras **1402A-1402B** may further include a filter **1454** aligned to the optical axis **1460** by the housing **1462** before the light rays reach the image sensor **1451**. The filter **1454** may be used to filter out excessive light generated by the laser generator for laser cutting. The filter **1454** may be particularly tuned to filter out the wavelength of light used for laser cutting while allowing lights of other wavelengths to pass through into the image sensor **1451**. For example, the laser may be chosen to emit a 532 nm wavelength (green laser light) over a power range of about 25-60 watts. To avoid the laser light from saturating the image sensor **1451** in each video camera **1402A-1402B**, the filter **1454** may be tuned to filter out green light around a wavelength of 532 nanometers.

An electrical cable **1466** may be coupled to the image sensor **1451** of each of the one or more cameras **1402A-1402B** to provide power to the image sensor **1451** and transfer digital data of the captured images through the tool **1018** to the control consoles **150A-150B**. One of the one or more electronic interface connectors **1314** may couple to the electrical cables **1466** to facilitate the removal and replacement of the combined laser ablation-imaging robotic surgical tool **1018**.

Referring now to FIG. **15A**, the end effector **1348A** may include one or more alignment tabs **1502A-1502B** as part of the enclosure **1465**. The one or more alignment tabs may extend along the body of the tool **1018** so that the one or more cameras and each image sensor **1451** is retained in alignment with the end effector **1348** and its controlled movement.

Referring now to FIGS. **14B-15B** and the end effector **1348B**, the combined laser ablation-imaging robotic surgical tool **1018** at its distal end includes the one or more cameras **1402A-1402B** and a laser diode **1480** instead of the fiber optic cable. The plurality of light pipes or fiber optic cables **1436** are bundled together into one or more channels **1490** as illustrated in FIG. **15B** to provide lighting for the one or more cameras **1402A-1402B**. A transparent cover may be hermetically sealed to the enclosure **1465** over the end of the plurality of light pipes or fiber optic cables **1436** to avoid body fluids from seeping into the end effector so that the tool can be readily sterilized. Light for the plurality of light pipes or fiber optic cables **1436** may be generated by one or more light emitting diodes (LED) in the tool such as to the diode **708** illustrated in FIG. **7A**, or alternatively generated by an external illuminator such as a Xenon short-arc lamp, or by other well-known means. Alternatively, one or more light emitting diodes (LED) may be included as part of the end effector, space permitting, instead of the using the plurality of light pipes or fiber optic cables **1436**.

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As shown in FIG. 14B, the laser diode **1480** is coupled to one end of an electrical cable **1486** to provide power and to control the generation of the laser light along an optical axis **1482**. Another end of the electrical cable **1486** is coupled to one or more of the electronic interface connectors **1314** of the tool **1018** to couple to a laser controller, such as the laser controller/generator **102B** illustrated in FIGS. 1A, 1C.

From the laser diode **1480**, laser light passes through a transparent cover or window **1481B** and out of the tool into a body cavity. The transparent cover **1481B** may be hermetically sealed to the enclosure **1465** of the end effector **1348B** to avoid body fluids from seeping into the end effector so that the tool can be readily sterilized. A focusing lens or lens system **1427B** may be located between the active region of the laser diode **1480** and the inside surface of the transparent cover or window **1481B**, and functions to collimate and or focus the laser light diverging from the active region of the laser diode, or to focus it in order to attain maximum energy density at a desired distance from the external surface of the transparent cover or window **1481B**.

When lasing, the laser diode **1480** may generate heat. The laser diode **1480** may be coupled to a heat removal device **1484**, such as a passive heat sink or slug. Additionally or alternatively, a fluid channel **1492** may be routed through the tool **1018** adjacent the laser diode **1480** to transfer heat away from it. The fluid may also flow through the channel and out of the tool **1018** into a body cavity to irrigate it. If the channel is under suction, fluid may flow out of the body cavity into the channel **1492**, along the laser diode **1480** to cool it, and out of the tool **1018**. If the laser diode **1480** is of sufficiently low power, liquid cooling by a fluid channel may be unnecessary.

A similar fluid channel may be made available in the combined laser-ultrasound tool to cool down a heated ultrasound probe. However, as the ultrasound tool may be in front of the combined laser-camera tool, the fluid channel **1492** of the combined laser-camera tool or a dedicated suction/irrigation tool may be used to douse the ultrasound probe with a cool liquid to remove heat there-from.

Referring now to FIG. 9, the combined laser-endoscopic camera tool **1018** captures images of a surgical site for display in the viewer of the surgeon's console. A bulls eye **920** may be computer generated and overlaid onto the images of the surgical site for display in the viewer. The bulls eye **920** may indicate the point where the laser can mark or cut tissue within the field of view of the surgical site. As an endoscopic camera is usually used to capture images of a surgical site, combining the laser with the camera provides an additional tool that a surgeon may use to cut tissue without using additional cannulas or ports of entry into the surgical site.

Moreover, with reference to FIGS. 1D and 9, one surgeon O operating at a first console **150A** may be manipulating the tools **910L**, **910R** within the surgical site **900** while another surgeon M may be operating the laser of the combined laser-endoscopic camera tool **1018** at a second console **150B**. The second surgeon operating the combined laser-endoscopic camera tool may help reduce the time spent performing a minimally invasive surgery.

CONCLUSION

While this specification includes many specifics, these should not be construed as limitations on the scope of the disclosure or of what may be claimed, but rather as descriptions of features specific to particular implementations of the disclosure. Certain features that are described in this speci-

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fication in the context of separate implementations may also be implemented in combination in a single implementation. Conversely, various features that are described in the context of a single implementation may also be implemented in multiple implementations, separately or in sub-combination. Moreover, although features may be described above as acting in certain combinations and even initially claimed as such, one or more features from a claimed combination may in some cases be excised from the combination, and the claimed combination may be directed to a sub-combination or variations of a sub-combination. The claimed invention is limited only by patented claims that follow below.

What is claimed is:

1. A method of using endoscopic surgical tools, the method comprising:

inserting a first endoscopic surgical tool into a body cavity having a surgical site, the endoscopic surgical tool comprising a hermetically sealed enclosure including an image capture device and a laser emitting device; capturing images of tissue in the surgical site with the image capture device;

displaying the images on a display device;

overlaying a computer generated bulls-eye target on the display device, the computer generated bulls-eye target overlaid at a first location where the laser emitting device is focused to target tissue with a laser light beam;

energizing the laser emitting device to emit the laser light beam out of the first surgical tool and onto the targeted tissue in the surgical site at the computer generated bulls-eye target;

generating a first virtual dot on the image of the surgical site displayed by the display device to mark the first location where the laser emitting device was energized; and

wherein moving the computer generated bulls-eye target and energizing the laser emitting device generates a second virtual dot on the image of the surgical site at a second location;

wherein the computer generated bull-eye target is generated by one or more processors in communication with the first surgical tool, the display device, and the laser emitting device.

2. The method of claim 1, further comprising:

adjusting power of the laser light beam to cut tissue, and wherein the energizing of the laser emitting device cuts tissue in the surgical site.

3. The method of claim 1, further comprising:

adjusting power of the laser light beam to mark tissue, and wherein the energizing of the laser emitting device marks tissue in the surgical site.

4. The method of claim 3, further comprising:

capturing video images of tissue in the surgical site with a second surgical tool;

viewing the video images including the marked tissue;

performing surgery on tissue within the surgical site using a third surgical tool and a fourth surgical tool in the surgical site using the video images of the marked tissue as a guide.

5. The method of claim 4, wherein

the first surgical tool is controlled by a first user to mark tissue;

the second surgical tool, the third surgical tool, and the fourth surgical tool are controlled by a second user to perform surgery on tissue within the surgical site guided by the marked tissue; and

the method further comprises pointing to anatomy in the surgical site with the second surgical tool using a low power laser.

6. The method of claim 1, wherein
the captured images are ultrasound images captured by an ultrasound probe in the first surgical tool and displayed onto the display device. 5

7. The method of claim 6, wherein
the capturing of ultrasound images includes positioning the ultrasound probe near tissue in the surgical site. 10

8. The method of claim 7, wherein
the capturing of ultrasound images further includes moving the ultrasound probe over the tissue to capture a plurality of ultrasound images.

9. The method of claim 1, wherein 15
the captured images are video images captured by at least one video camera in the first surgical tool and displayed onto the display device.

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专利名称(译)	用于激光打标和激光切割的手术工具		
公开(公告)号	US10368838	公开(公告)日	2019-08-06
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[标]申请(专利权)人(译)	直观外科手术公司		
申请(专利权)人(译)	Intuitive Surgical公司, INC.		
当前申请(专利权)人(译)	Intuitive Surgical公司运营, INC.		
[标]发明人	WILLIAMS MATTHEW REAGAN DACHS II GREGORY WILLIAM SHAFFER DAVID		
发明人	WILLIAMS, MATTHEW REAGAN DACHS, II, GREGORY WILLIAM SHAFFER, DAVID		
IPC分类号	A61B34/00 A61B34/30 A61B90/30 A61B8/12 A61B8/00 A61B34/37 A61B18/22 A61B18/20 A61B17/00 A61B90/00		
CPC分类号	A61B8/4488 A61B8/12 A61B8/445 A61B34/30 A61B34/37 A61B34/71 A61B90/30 A61B2090/378 A61B18/22 A61B90/361 A61B2017/00477 A61B2018/2025 A61B2034/305 A61B2090/3614 A61B2090 /371		
其他公开文献	US20090248041A1		
外部链接	Espacenet		

摘要(译)

在本发明的一个实施例中, 机器人手术系统包括组合的激光成像机器人手术工具, 控制台和激光发生器/控制器。该工具安装在患者侧推车的第 一机械臂上。该工具具有褶皱关节和连接在一起的末端执行器。末端执 行器具有激光发射装置以将激光束引导到手术部位中的组织上, 并且具 有图像捕获装置以捕获手术部位中的组织的图像。与工具通信的控制台 接收手术部位中捕获的组织图像, 并将捕获的图像显示在显示设备上给 用户。激光发生器/控制器耦合到工具和控制台, 以控制激光束发射到手 术部位的组织上。

