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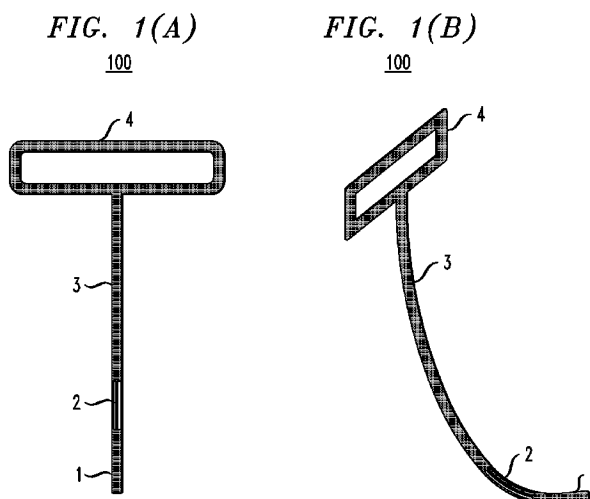
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(54) Title: INTRODUCER FOR SURGICAL AIRWAY CATHETERS



(57) Abstract: An introducer for a surgical airway catheter has a proximal handle; a curved, rod-shaped main section; a cutting region; and a rod-shaped distal tip, all (except the handle) sized to receive the catheter tube. After making an initial opening in a patient's trachea, the operator inserts the distal tip of the introducer into the initial opening up to the cutting region. The operator uses the cutting region to sufficiently widen the opening by moving the introducer from side to side to enable the widened opening to receive the tube and cuff of the catheter. The operator rotates the introducer and catheter into the trachea through the widened opening and then removes the introducer leaving the catheter in place. The introducer and catheter can be pre-configured in a surgical kit that includes a retractable scalpel that can be configured onto the introducer's handle and used to excise the initial tracheal opening.

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INTRODUCER FOR SURGICAL AIRWAY CATHETERS

Cross-Reference to Related Applications

This application claims the benefit of the filing date of U.S. provisional application no.
5 61/251,776, filed on 10/15/09 as attorney docket no. 1056.002PROV, the teachings of which are
incorporated herein by reference in their entirety.

BACKGROUND

Field of the Invention

10 The present invention relates to medical devices and techniques for using medical devices and,
more specifically but not exclusively, to an introducer for surgical airway catheters.

Description of the Related Art

This section introduces aspects that may help facilitate a better understanding of the invention.
15 Accordingly, the statements of this section are to be read in this light and are not to be understood as
admissions about what is prior art or what is not prior art.

Emergency cricothyrotomy or tracheotomy can be performed using a traditional open technique
(scalpel and tracheal hook), trochar-type devices, or with a wire-guided percutaneous approach using
dilators (a.k.a. Seldinger technique). The preferred emergency surgical airway insertion site is the
20 cricothyroid membrane because it is a relatively large space, it is devoid of large blood vessels, and it is
generally accessible regardless of body habitus.

Open techniques involve a skin incision, stabilization of the trachea with either a tracheal hook or
other instrument, and subsequent placement of a tracheal tube or surgical airway tube (tracheostomy tube
or other short airway catheter) directly into the opening. These techniques are intimidating to providers
25 without formal surgical training. Open techniques require fine motor control under situations of marked
duress for operators and extreme time constraints for patients. Examples of these situations include hostile
battlefield and tactical situations, in addition to traumatic presentations to emergency departments. Risks
include vascular injury of laterally adjacent structures, perforation of the posterior trachea, creation of false
subcutaneous passages, and fractures of the thyroid or cricoid cartilages due to the tracheal hook. Open
30 surgical techniques are also technically challenging due to variations in the thickness of anterior neck
tissues and bleeding that obscures landmarks. If control of the trachea by the tracheal hook is lost during
the procedure, the opening may retract and be difficult to re-identify.

Trochar-type devices use sharp pointed blunt or hollow points to enter the skin and puncture the
trachea, after which an airway tube is inserted (either over or through the sharp trochar). Upon insertion,
35 the direction of force is in an anterior to posterior direction. This can cause compression of the trachea

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(decreasing the anterior posterior dimension) due to sudden and forceful entry into the trachea. The sharp point of such a device may then puncture the thin wall of the posterior trachea. This can result in procedural failure, false passage, mediastinal injury, subcutaneous emphysema, and tension pneumothorax. If the insertion point is off midline, then the great vessels of the neck (carotid artery and jugular vein) may be disrupted resulting in major bleeding. In many clinical situations that require surgical airway access, there is injury to the neck that may distort landmarks and proper identification of midline may be difficult.

Wire-guided percutaneous devices are less intimidating to providers since a needle is used to place a wire into the trachea and no direct skin or tracheal incision is required. A skin or tissue plug in the needle may make identification of the trachea with a needle difficult or impossible. It is also possible to create a false passage with the wire. After the wire is placed, a dilator is used to serve as a stent for a cuffed short airway tube. To pass the dilator, the skin incision must be enlarged. Passage of the dilator and tube involves a relative sharp turn into the trachea. Expanding the skin incision requires cutting down on the wire using fine motor control of the scalpel while holding the wire in place. An inadequate skin incision, or an inappropriate insertion angle of the dilator and tube, may make passage into the trachea mechanically difficult. It can be difficult to control both dilator and tube during forceful insertion over the wire. The percutaneous method requires an average of 100 seconds before the patient can be ventilated. Since there is great reluctance for operators to initiate surgical airways, an additional 100-second delay to ventilation may result in hypoxic injury or death.

SUMMARY

A published article by Paladino, DuCanto, and Manoach describes use of a rigid optical stylet for stabilizing the trachea after neck incision, followed by direct visualization of the trachea through the fiberoptic instrument. See "Development of a rapid, safe, fiber-optic guided, single-incision cricothyrotomy using a large ovine model: a pilot study," Paladino L., DuCanto J., and Manoach S., Resuscitation, 2009 Sep; 80 (9):1066-9 (Epub 2009 Jul 15). After the opening is expanded with another scalpel incision, the authors passed a pre-loaded, snug-fitting short airway tube over the stylet into the trachea.

Problems in the prior art are addressed in accordance with the principles of the present invention by providing technique for inserting a surgical airway catheter using an introducer that is simpler than the device described by Paladino et al. and without the need for fiberoptic guidance.

In one embodiment, the present invention is an introducer for inserting a surgical airway catheter into an opening in a patient's trachea. The introducer comprises (i) a handle at a proximal end of the introducer, (ii) a rod-shaped main section connected to the handle, (iii) a cutting region connected to the main section, and (iv) a rod-shaped distal tip connected to the cutting region. The cutting region enables

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an operator of the introducer to widen an initial opening in the trachea by moving the introducer from side to side after inserting the distal tip inserted into the opening in the trachea and with the cutting region positioned at the opening.

In another embodiment, the present invention is a sealed surgical kit for inserting a surgical airway catheter into an opening in a patient's trachea. The surgical kit comprises the catheter and an introducer as described above.

In yet another embodiment, the present invention is a method for inserting a surgical airway catheter into an opening in a patient's trachea. The method comprises (a) excising an initial opening in the trachea, (b) inserting a distal tip of an introducer into the initial opening with the catheter pre-configured on the introducer, (c) widening the opening using a cutting region of the introducer, and (d) rotating the introducer and catheter into the trachea through the widened opening and then removing the introducer.

BRIEF DESCRIPTION OF THE DRAWINGS

Other aspects, features, and advantages of the present invention will become more fully apparent from the following detailed description, the appended claims, and the accompanying drawings in which like reference numerals identify similar or identical elements.

Figs. 1(A) and 1(B) show front and perspective views, respectively, of an introducer according to one embodiment of the present invention;

Fig. 2 shows a cross-sectional side view of the introducer of Fig. 1 inserted into a surgical airway catheter;

Figs. 3(A)-(E) show different views of the distal tip, the cutting region, and/or a portion of the main section of the introducer of Fig. 1;

Figs. 4(A)-(B) show front views of a portion of the introducer of Fig. 1 according to a particular implementation in which the handle of the introducer has an integrated, retractable scalpel;

Fig. 5 shows a flow diagram of a method for using the introducer of Fig. 1.

DETAILED DESCRIPTION

Figs. 1(A) and 1(B) show front and perspective views, respectively, of an introducer **100** according to one embodiment of the present invention. As shown, introducer **100** has handle **4**, main section **3**, cutting region **2**, and distal tip **1**. Introducer **100** can be made from a rod of suitable material, such as metal (e.g., steel or aluminum) or plastic.

Fig. 2 shows a cross-sectional side view of introducer **100** of Fig. 1 inserted into a surgical airway catheter **200**. As shown, catheter **200** has a flexible tube **5** with a standard 15-mm connector **7** at one end that, after withdrawal of the introducer) can be connected to a manual resuscitator (a.k.a. a bag valve mask or an Ambu bag) or a ventilatory circuit. The catheter has a taper **8** at the other end and an intermediate

cuff **6** for sealing the trachea upon inflation of the cuff. The outer dimensions of the thin, round, rod-shaped main section **3**, cutting region **2**, and thin, round, rod-shaped distal tip **1** of introducer **100** closely approximate the inner dimensions of flexible tube **5** of catheter **200**.

Fig. 3(A) shows an enlarged front view of distal tip **1**, cutting region **2**, and a portion of main section **3** of introducer **100** of Fig. 1. Figs. 3(B), 3(C), and 3(D) shows lateral cross-sectional views of distal tip **1**, cutting region **2**, and main section **3**, respectively. Fig. 3(E) shows an enlarged version of the lateral cross-sectional view of cutting region **2** of Fig. 3(C).

Figs. 4(A) and 4(B) show front views of a portion of introducer **100** of Fig. 1 according to a particular implementation in which handle **4** has an integrated, retractable scalpel **400**. In particular, Fig. 4(A) shows scalpel **400** with its blade in a retracted position, while Fig. 4(B) shows scalpel **400** with its blade in an extended position, as controlled by the thumb of an operator of introducer **100**.

Catheter **200** is flexible enough to easily insert into an incision in the neck and trachea. Introducer **100** should be of sufficient diameter so there is no gap between the outer surface of main section **3** of the introducer and the inner surface of tube **5** of the catheter, but not too tight as to inhibit easy sliding of the catheter off of the introducer. A good fit between the introducer and the catheter is also helpful for inserting the introducer and the catheter as a unit into an incision in the neck and into an opening in the trachea.

Introducer **100** has an overall curved shape facilitating both storage and easy passage of a short surgical airway catheter, such as catheter **200**. The proximal end of introducer **100** has a T-shape that forms handle **4**. Main section **3** of introducer **100** has a gentle curve of sufficient length to match an appropriately sized surgical airway. Main section **3** may be made more or less flexible based on the rod material selected to form introducer **100**. In general, main section **3** should have an appropriate balance of flexibility and stiffness to enable efficient insertion of the introducer and catheter into a patient's trachea. As shown in Fig. 2, connector **7** at the proximal end of catheter **200** stops against the T-shaped handle **4**. At the distal end of catheter **200**, taper **8** provides a tapered fit against main section **3** of introducer **100**. As shown in Figs. 1(B) and 2, distal tip **1** of introducer **100** has (i) an upward bend towards handle **4** of between about 20 degrees and about 40 degrees relative to main section **3** and (ii) a smooth rounded tip.

Cutting region **2**, located between distal tip **1** and main section **3** of introducer **100**, is a short section of rod that has a diamond-shaped cross-sectional appearance, as shown in Figs. 3(C) and 3(E). The diamond-shaped cutting region **2** has four edges corresponding to 0 degrees, 90 degrees, 180 degrees, and 270 degrees, as represented in Fig. 3(E). When inserted into a patient, the 0-degree edge is anterior, the 180-degree edge is posterior, and the 90- and 270-degree edges correspond to the patient's left and right sides. The distance between the 0-degree and 180-degree edges approximates the diameter of the rod used to form distal tip **1** and main section **3**. The distance between the edges at 90 degrees and 270 degrees does not exceed that rod diameter. The 0- and 180-degree edges (i.e., the anterior and posterior

edges) have smooth surfaces. In contrast, the lateral edges (i.e., at 90 degrees and 270 degrees) of the diamond-shaped cutting region **2** are sharp enough to expand a horizontal (e.g., from patient right to patient left) incision made in the trachea, but not so sharp as to easily cut the operator's skin if accidentally touched. Note that, as shown in Fig. 3(A), the sharp lateral edges are tapered (**9**) at both sides and both ends to meet the rounded rods above and below. Coupled with the rounded 0- and 180-degree edges (which match the rod's diameter), the taper **8** at the distal end of catheter **200** will not catch as it slides over the diamond-shaped cutting region **2** of introducer **100**, either upon loading the catheter or advancing it off of the introducer. The edges at 90 degrees and 270 degrees are also not sharp enough to cut into the airway catheter. In alternative embodiments, one or both of the dimensions of the diamond-shaped cutting region **2** may be smaller than the rod diameter.

For certain implementations, cutting region **2** may be made entirely of the same rod material as the other elements of introducer **100**. For those implementations, the rod material must be pressed or molded into the shape shown in Fig. 3 to provide both the sharp lateral edges and the smooth anterior and posterior edges. For other implementations, cutting region **2** may be a composite of different materials. For example, the smooth edges may be formed of the same (e.g., plastic) material used for the other elements of the introducer, while the sharp edges may be metal blades mounted in that plastic material.

Handle **4** of the introducer has dimensions sufficient to allow an easy grip. In the embodiment of introducer **100**, the handle is symmetric in shape in both its long axis (i.e., perpendicular to the longitudinal axis of the introducer's main section **3** and its short axis (i.e., parallel to the longitudinal axis of main section **3**). The handle is of sufficient length such that the housing of a retractable scalpel, such as retractable scalpel **400** of Fig. 4, could be snapped or secured onto the top of the handle, with the scalpel blade pointing in either direction allowing single-finger control, as represented in Fig. 4. In the configuration shown in Fig. 4, the operator's right thumb is extending the scalpel blade toward the left. An alternative configuration could have the scalpel oriented on the handle to allow a left-handed operator the ability to extend the scalpel blade in the other direction.

In the intended use of introducer **100**, the operator's non-dominant hand is used to identify laryngeal landmarks and stabilize the trachea and thyroid cartilage. The operator can be either at the patient's side or at the head of the bed above the supine patient. A retractable scalpel, such as retractable scalpel **400** of Fig. 4, is secured longitudinally in the handle (as shown in Fig. 4) and oriented to match the intended right- or left-hand use of the operator. Introducer **100** is held by handle **4** in the operator's dominant hand with the tips of the thumb and first two or three fingers of that dominant hand surrounding main section **3**. The thumb can be moved out or in on top of the scalpel to either extend or retract the blade.

After the scalpel blade is exposed by the operator's dominant thumb (as in Fig. 4(B)), a small, initial, horizontal (e.g., from patient left to patient right for a right-handed operator) incision is made into

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the trachea of a size to permit insertion of the distal tip **1** of the introducer. The scalpel blade is then retracted into a safe position by the operator's thumb (as in Fig. 4(A)). The rounded distal tip **1** of the introducer is inserted into the small opening in the trachea. The rigidity of the overall introducer and the rounded curvature allow the distal tip to be curved into the trachea. Upon insertion, the only portions of the introducer that can touch the posterior trachea (e.g., distal tip **1**, the 180-degree edge of cutting region **2**, and main section **3**) are smooth and rounded to prevent puncture of the posterior trachea. The anterior (0-degree) edge of the diamond-shaped cutting region **2** is also smooth and rounded to prevent damage to the anterior cricoid ring.

Handle **4** is used to lift up and control the trachea in a manner that gives the operator tactile confirmation of proper entry into the trachea, e.g., when partially retracting the introducer from the opening. If the distal tip of the introducer is under the skin, but not in the trachea, then the neck skin will tent and feel different from when the trachea is being properly controlled. By tilting the distal tip of the introducer anteriorly within the trachea, and also up and down inside the trachea, the operator feels the rounded distal tip riding over the anterior tracheal rings. With tactile feedback from both tracheal control and the tip interaction with the rings, the tracheal location of the device is assured.

The next step involves a quick side-to-side (i.e., between patient left and patient right) movement of the introducer contacting the sharpened lateral (i.e., 90- and 270-degree) edges of the diamond-shaped cutting region **2** with the lateral margins of the initial opening into the trachea. By this side-to-side movement, the opening into the trachea is expanded without the need for a scalpel or Trousseau dilator. Since the outer diameters of the catheter's tube **5** and cuff **6** are larger than the diameter of the distal tip **1** of the introducer, enlarging the opening will enable passage of the catheter's tube and cuff into the trachea. With the distal tip **1** in the trachea, and the opening expanded as described, the operator's other hand is used to push the pre-loaded short airway tube **5** along with cuff **6** off the introducer and fully into the trachea (up to connector **7**). After insertion of airway catheter **200**, introducer **100** is rotated backward out of the trachea, and the airway catheter is secured. Alternatively, it is possible to fully advance the introducer and the catheter as a unit into the trachea up to connector **7**, and then withdraw the introducer leaving the catheter in place.

Fig. 5 shows a flow diagram of a method **500** for using introducer **100** of Fig. 1 already configured with catheter **200** and retractable scalpel **400**. At step **502**, the operator extends the scalpel blade and excises the trachea. At step **504**, the operator retracts the scalpel blade. At step **506**, the operator inserts distal tip **1** and uses the introducer to feel and control the trachea. At step **508**, the operator widens the initial opening using the diamond-shaped edges of cutting region **2**. At step **510**, the operator rotates the introducer and the airway catheter into the trachea through the widened opening and removes the introducer leaving the catheter in place.

The dimensions of introducer **100** can be designed to fit, e.g., larger surgical airway catheters for adult patients or smaller surgical airway catheters for pediatric patients. Introducer **100** can also be used to replace tracheotomy tubes that have fallen out.

Embodiments of the present invention, such as introducer **100**, can provide one or more of the following advantages:

- 1) Only three separate items are needed (i.e., introducer **100**, catheter **200**, and retractable scalpel **400**). Since the tube can be pre-loaded on the introducer, there would be only two pieces of equipment when initially opening a sealed surgical kit for the introducer (i.e., the scalpel and the combined tube and introducer). Moreover, since most people are right-handed, the scalpel can also come pre-assembled into the introducer's handle in the configuration suitable for a right-handed operator. In any case, with a retractable scalpel either attached to or built into the handle, the three components become one piece of equipment to hold. This compares to a standard surgical kit that involves at least three loose items, e.g., a tracheal hook, a scalpel, an airway tube, and possibly other retractors. Percutaneous wire-guided devices have many more items, e.g., a needle, a syringe, a wire, a scalpel, an airway tube, and a dilator. Introducer **100** can be packed in a hermetically sealed surgical kit with a scalpel and airway catheter, where the kit can be compressed without any significant risk to proper function. There is nothing to break with the pre-loaded airway tube on the introducer. There are also no exposed sharp points that can puncture other items in a medical kit or an operator if the device is stored in a leg pocket or waist belt bag. This is in contradistinction to tracheal hooks, needles, trochar systems, etc.
- 2) The trachea is incised initially without significant force, lessening the risk of injury to the posterior wall. Only a small, initial incision is need in the anterior trachea to introduce the small round tip of the introducer. The introducer is then used to lift and control the trachea, so that, when the catheter tube is advanced down, the tube is not being directed at the posterior wall upon insertion.
- 3) Apart from the initial cut into the trachea, there is no need for repeat use of the scalpel. With some methods, a scalpel is used for initial skin incision and also to enlarge the tracheal opening after something has been placed into the opening. With the percutaneous technique, the scalpel is used initially to nick the skin and again to widen the opening adjacent to the wire. The sharpened lateral edges of the introducer's cutting region **2** provide widening of the initial opening without having to pick up the scalpel again. This is much faster and eliminates the need for fine hand control. It also eliminates the problem of losing or contaminating the scalpel after putting it down. Compared to any other means of surgical airway access, there is a marked reduction in the number of fine motor steps involved in the present invention.
- 4) The introducer and method involve no articulating parts and no springs. As noted, a retractable scalpel could be incorporated into the handle and easily controlled by thumb extension or flexion. Disposable surgical scalpels with retractable blades or guards are in common use.

5 5) There is a reduced risk of passing a tube into a false passage. If the tip of the introducer is not in the trachea, then the trachea will not be palpably controlled with side-to-side movements, and the rings will not be felt with up and down tip movements against the anterior rings. If the tip is in the subcutaneous skin, then the tip will tent up against the skin. This has a much different feel from when the tip is in the trachea.

6) The introducer can be constructed from steel or fashioned from a hardened plastic. It can be simply and inexpensively produced.

10 7) The operator's non-dominant hand never has to leave the landmarks of the thyroid and neck. The dominant hand never has to let go of the introducer (pre-configured with an integrated scalpel and overlying airway catheter). This permits an operator to perform the procedure without needing an assistant to pass instruments. There are reduced risks of losing a piece of equipment and of provider injury resulting from multiple operators with hands in the surgical field. The net effects of the design and integration of components are decreased time until intubation is achieved and improved safety for both operator and patient. From an instructional perspective, the method is much simpler to teach and
15 ergonomically easier to learn than any other method of inserting a surgical airway.

In certain embodiments, the introducer is made from a solid rod. In other embodiments, the introducer is made from a hollow rod that is open both at the handle and at the distal tip. Note that the opening at the distal tip can be either at the end of the distal tip or along the side of the distal tip. If made from a hollow rod, when the introducer is inserted into the trachea of a breathing patient, air may pass
20 through the hollow rod from the opening at the distal tip to the opening at the handle. Such air flow may produce an audible sound that would provide additional confirmation to the operator that the introducer was successfully inserted into the trachea. In addition, the rod opening at the handle may be specifically shaped to function as a whistle or a whistle may be attached to that handle opening to enhance the audible sound produced.

25 Unless explicitly stated otherwise, each numerical value and range should be interpreted as being approximate as if the word "about" or "approximately" preceded the value of the value or range.

It will be further understood that various changes in the details, materials, and arrangements of the parts which have been described and illustrated in order to explain the nature of this invention may be made by those skilled in the art without departing from the scope of the invention as expressed in the
30 following claims.

The use of figure numbers and/or figure reference labels in the claims is intended to identify one or more possible embodiments of the claimed subject matter in order to facilitate the interpretation of the claims. Such use is not to be construed as necessarily limiting the scope of those claims to the embodiments shown in the corresponding figures.

Reference herein to "one embodiment" or "an embodiment" means that a particular feature, structure, or characteristic described in connection with the embodiment can be included in at least one embodiment of the invention. The appearances of the phrase "in one embodiment" in various places in the specification are not necessarily all referring to the same embodiment, nor are separate or alternative
5 embodiments necessarily mutually exclusive of other embodiments. The same applies to the term "implementation."

The embodiments covered by the claims in this application are limited to embodiments that (1) are enabled by this specification and (2) correspond to statutory subject matter. Non-enabled embodiments and embodiments that correspond to non-statutory subject matter are explicitly disclaimed even if they fall
10 within the scope of the claims.

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CLAIMS**What is claimed is:**

1. An introducer (e.g., **100**) for inserting a surgical airway catheter (e.g., **200**) into an opening in a patient's trachea, the introducer comprising:
 - 5 a handle (e.g., **4**) at a proximal end of the introducer;
 - a rod-shaped main section (e.g., **3**) connected to the handle;
 - a cutting region (e.g., **2**) connected to the main section; and
 - a rod-shaped distal tip (e.g., **1**) connected to the cutting region, wherein the cutting region enables an operator of the introducer to widen an initial opening in the trachea by moving the introducer from side to side after inserting the distal tip inserted into the opening in the trachea and with the cutting region positioned at the opening.
- 10 2. The introducer of claim 1, wherein the handle is designed to receive a retractable scalpel (e.g., **400**) that can be used by the operator to excise the initial opening in the trachea, wherein the initial opening is large enough to receive the distal tip and the cutting region of the introducer.
- 15 3. The introducer of claim 2, wherein the handle is adapted to receive the retractable scalpel in either a right-handed configuration or an opposing, left-handed configuration wherein the scalpel can be selectively configured such that a blade of the scalpel is extendable in one direction relative to the handle for the right-handed configuration and in the opposite direction for the left-handed configuration.
- 20 4. The introducer of claim 1, wherein outer dimensions of the main section, the cutting region, and the distal tip of the introducer are designed to be inserted into the catheter.
- 25 5. The introducer of claim 1, wherein:
 - the catheter has a tube (e.g., **5**) and a cuff (e.g., **6**) positioned over the tube; and
 - the cutting region is designed to sufficiently widen the opening for receiving the tube and the cuff of the catheter.
- 30 6. The introducer of claim 1, wherein the cutting region has (i) two opposing, cutting edges (e.g., 90- and 270-degree edges of Fig. 3(E)) and (ii) two opposing, rounded edges (e.g., 0- and 180-degree edges) oriented 90 degrees from the cutting edges.

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7. The introducer of claim 6, wherein the distance between the two cutting edges of the cutting region and the distance between the two rounded edges of the cutting region are both not bigger than either a diameter of the rod-shaped main section or a diameter of the rod-shaped distal tip.

5 8. The introducer of claim 6, wherein ends of the two cutting edges are beveled (e.g., 9) at the connections to the main section and the distal tip.

9. The introducer of claim 1, wherein the main section of the introducer has a curved shape that enables the distal tip, the cutting region, and the main section of the introducer to be rotated into the
10 trachea through the opening.

10. The introducer of claim 9, wherein the distal tip is bent towards the handle at an angle between about 20 degree and about 40 degrees relative to a longitudinal axis of the cutting region.

15 11. The introducer of claim 1, wherein the introducer is hollow with openings at the distal tip and handle to enable air to flow through the introducer producing an audible sound.

12. The introducer of claim 1, wherein:

the handle is designed to receive a retractable scalpel (e.g., 400) that can be used by the operator to
20 excise the initial opening in the trachea, wherein the initial opening is large enough to receive the distal tip and the cutting region of the introducer;

the handle is adapted to receive the retractable scalpel in either a right-handed configuration or an
opposing, left-handed configuration wherein the scalpel can be selectively configured such that a blade of
the scalpel is extendable in one direction relative to the handle for the right-handed configuration and in
25 the opposite direction for the left-handed configuration;

outer dimensions of the main section, the cutting region, and the distal tip of the introducer are
designed to be inserted into the catheter;

the catheter has a tube (e.g., 5) and a cuff (e.g., 6) positioned over the tube;

the cutting region is designed to sufficiently widen the opening for receiving the tube and the cuff of
30 the catheter;

the cutting region has (i) two opposing, cutting edges (e.g., 90- and 270-degree edges of Fig. 3(E)) and
(ii) two opposing, rounded edges (e.g., 0- and 180-degree edges) oriented 90 degrees from the cutting
edges;

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the distance between the two cutting edges of the cutting region and the distance between the two rounded edges of the cutting region are both not bigger than either a diameter of the rod-shaped main section or a diameter of the rod-shaped distal tip;

ends of the two cutting edges are beveled (e.g., **9**) at the connections to the main section and the distal tip; and

the main section of the introducer has a curved shape that enables the distal tip, the cutting region, and the main section of the introducer to be rotated into the trachea through the opening.

13. A sealed surgical kit for inserting a surgical airway catheter (e.g., **200**) into an opening in a patient's trachea, the surgical kit comprising:

the catheter; and

an introducer (e.g., **100**) comprising:

a handle (e.g., **4**) at a proximal end of the introducer;

a rod-shaped main section (e.g., **3**) connected to the handle;

15 a cutting region (e.g., **2**) connected to the main section; and

a rod-shaped distal tip (e.g., **1**) connected to the cutting region, wherein the cutting region enables an operator of the introducer to widen an initial opening in the trachea by moving the introducer from side to side after inserting the distal tip into the opening in the trachea and with the cutting region positioned at the opening.

20

14. The surgical kit of claim 13, wherein the catheter is pre-configured on the introducer prior to being sealed in the surgical kit.

15. The surgical kit of claim 13, further comprising a retractable scalpel (e.g., **400**) that can be used by the operator to excise the initial opening in the trachea, wherein the initial opening is large enough to receive the distal tip and the cutting region of the introducer.

16. The surgical kit of claim 15, wherein the handle is designed to receive the retractable scalpel.

17. The surgical kit of claim 16, wherein the handle is adapted to receive the retractable scalpel in either a right-handed configuration or an opposing, left-handed configuration wherein the scalpel can be selectively configured such that a blade of the scalpel is extendable in one direction relative to the handle for the right-handed configuration and in the opposite direction for the left-handed configuration.

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18. The surgical kit of claim 16, wherein the retractable scalpel is pre-configured in the handle of the introducer prior to being sealed in the surgical kit.

19. The surgical kit of claim 13, wherein outer dimensions of the main section, the cutting region, and the distal tip of the introducer are designed to be inserted into the catheter.

20. The surgical kit of claim 13, wherein:
the catheter has a tube (e.g., 5) and a cuff (e.g., 6) positioned over the tube; and
the cutting region is designed to sufficiently widen the opening for receiving the tube and the cuff of the catheter.

21. The surgical kit of claim 13, wherein the cutting region has (i) two opposing, cutting edges (e.g., 90- and 270-degree edges of Fig. 3(E)) and (ii) two opposing, rounded edges (e.g., 0- and 180-degree edges) oriented 90 degrees from the cutting edges.

22. The surgical kit of claim 21, wherein the distance between the two cutting edges of the cutting region and the distance between the two rounded edges of the cutting region are both not bigger than either a diameter of the rod-shaped main section or a diameter of the rod-shaped distal tip.

23. The surgical kit of claim 21, wherein ends of the two cutting edges are beveled (e.g., 9) at the connections to the rod-shaped main section and distal tip.

24. The surgical kit of claim 13, wherein the main section of the introducer has a curved shape that enables the distal tip, the cutting region, and the main section of the introducer to be rotated into the trachea through the opening.

25. The surgical kit of claim 24, wherein the distal tip is bent towards the handle at an angle between about 20 degree and about 40 degrees relative to a longitudinal axis of the cutting region.

26. The surgical kit of claim 13, wherein the introducer is hollow with openings at the distal tip and handle to enable air to flow through the introducer producing an audible sound.

27. The surgical kit of claim 13, wherein:

the handle is designed to receive a retractable scalpel (e.g., **400**) that can be used by the operator to
5 excise the initial opening in the trachea, wherein the initial opening is large enough to receive the distal tip
and the cutting region of the introducer;

the handle is adapted to receive the retractable scalpel in either a right-handed configuration or an
opposing, left-handed configuration wherein the scalpel can be selectively configured such that a blade of
the scalpel is extendable in one direction relative to the handle for the right-handed configuration and in
10 the opposite direction for the left-handed configuration;

outer dimensions of the main section, the cutting region, and the distal tip of the introducer are
designed to be inserted into the catheter;

the catheter has a tube (e.g., **5**) and a cuff (e.g., **6**) positioned over the tube;

the cutting region is designed to sufficiently widen the opening for receiving the tube and the cuff of
15 the catheter;

the cutting region has (i) two opposing, cutting edges (e.g., 90- and 270-degree edges of Fig. 3(E)) and
(ii) two opposing, rounded edges (e.g., 0- and 180-degree edges) oriented 90 degrees from the cutting
edges;

the distance between the two cutting edges of the cutting region and the distance between the two
20 rounded edges of the cutting region are both not bigger than either a diameter of the rod-shaped main
section or a diameter of the rod-shaped distal tip;

ends of the two cutting edges are beveled (e.g., **9**) at the connections to the main section and the distal
tip; and

the main section of the introducer has a curved shape that enables the distal tip, the cutting region, and the
25 main section of the introducer to be rotated into the trachea through the opening.

28. A method (e.g., **500**) for inserting a surgical airway catheter (e.g., **200**) into an opening in a
patient's trachea, the method comprising:

(a) excising (e.g., **502**) an initial opening in the trachea;

30 (b) inserting (e.g., **506**) a distal tip (e.g., **1**) of an introducer (e.g., **100**) into the initial opening with the
catheter pre-configured on the introducer;

(c) widening (e.g., **508**) the opening using a cutting region (e.g., **2**) of the introducer; and

(d) rotating (e.g., **510**) the introducer and catheter into the trachea through the widened opening and
then removing the introducer.

29. The method of claim 28, wherein steps (b), (c), and (d) are performed by one operator using one hand to continuously hold and maneuver the introducer.

30. The method of claim 29, wherein:
5 a retractable scalpel is configured to a handle of the introducer and used to perform step (a); and
steps (a), (b), (c), and (d) are performed by the one operator using the one hand to continuously hold and maneuver the introducer.

FIG. 1(A)
100

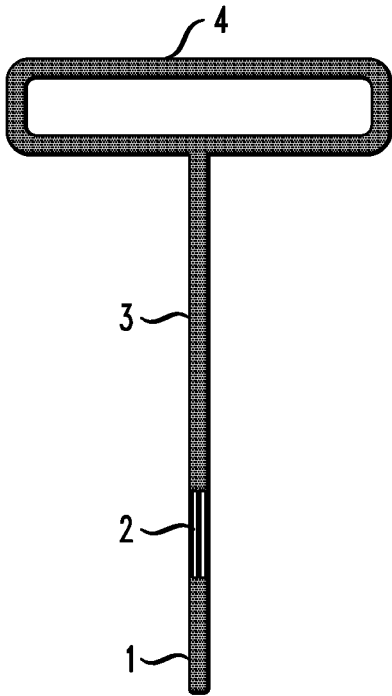


FIG. 1(B)
100

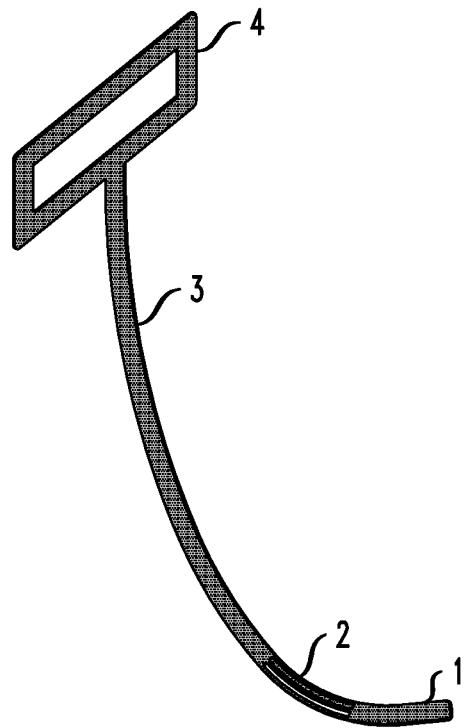


FIG. 2

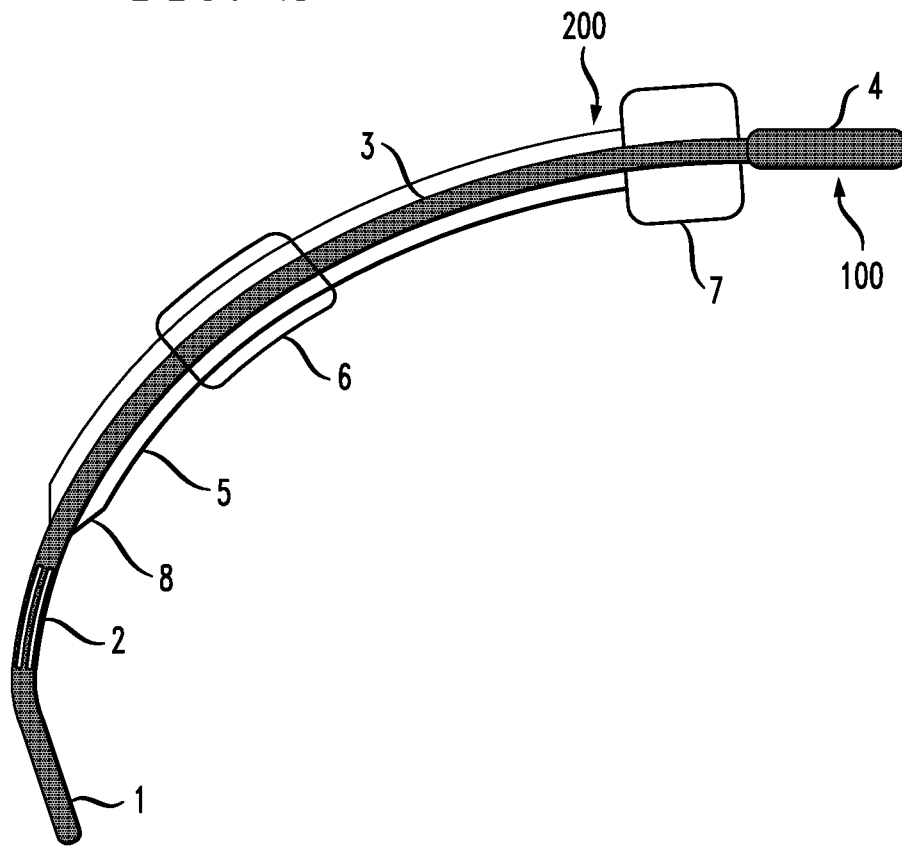


FIG. 3(A)

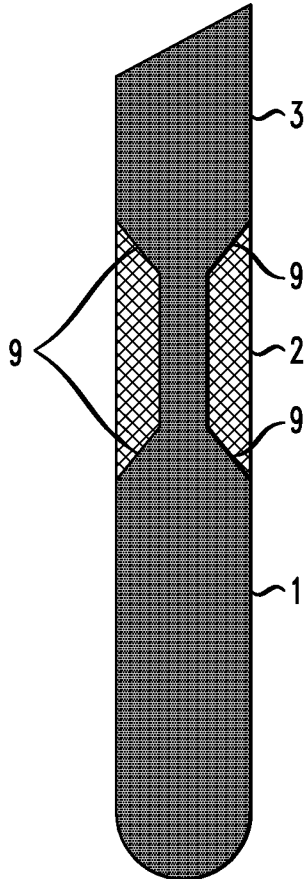


FIG. 3(D)

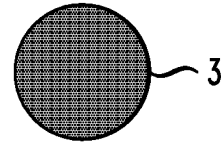


FIG. 3(C)

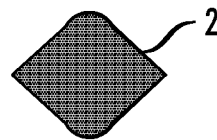


FIG. 3(B)

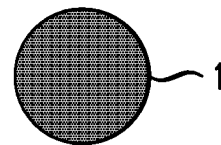


FIG. 3(E)

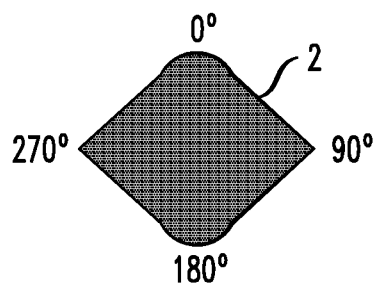


FIG. 4(A)

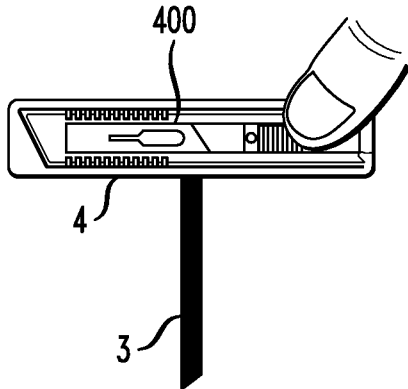


FIG. 4(B)

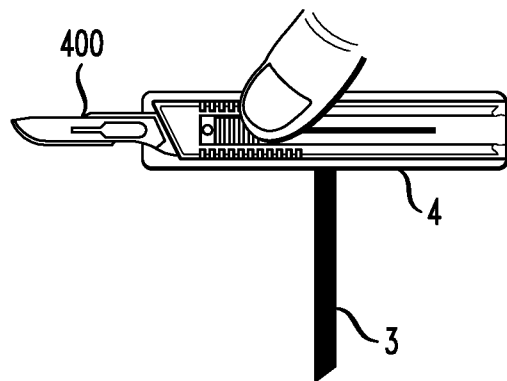
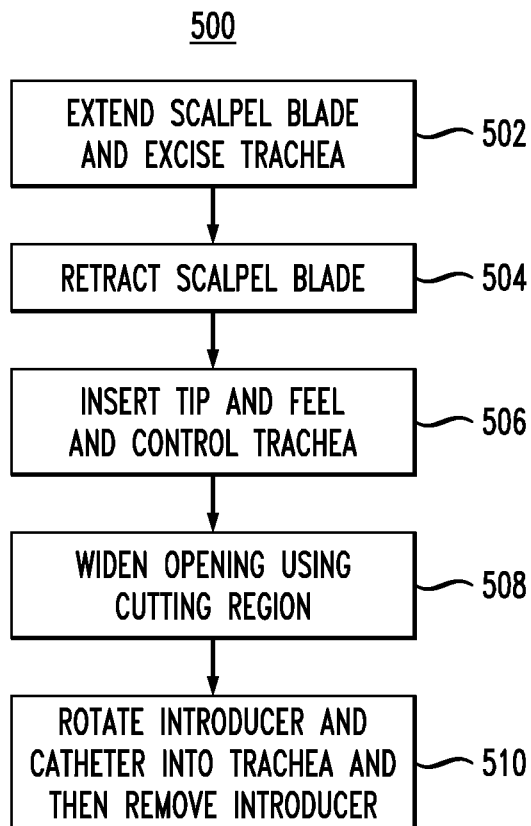


FIG. 5



INTERNATIONAL SEARCH REPORT

International application No
PCT/US2010/052798

A. CLASSIFICATION OF SUBJECT MATTER
 INV. A61B17/3209 A61B17/3211
 ADD. A61M16/04

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)
 A61B

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

Electronic data base consulted during the international search (name of data base and, where practical, search terms used)

EPO-Internal

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
A	US 2008/017195 A1 (YOSHIDA DOUGLAS K [US]) 24 January 2008 (2008-01-24) figures 8-13 paragraph [0045] - paragraph [0064]	1, 13
A	US 2005/279363 A1 (CRUZ RAFAEL [US]) 22 December 2005 (2005-12-22) paragraph [0026] - paragraph [0033] figures 5,6	1, 13

 Further documents are listed in the continuation of Box C.

 See patent family annex.

* Special categories of cited documents :

- *A* document defining the general state of the art which is not considered to be of particular relevance
- *E* earlier document but published on or after the international filing date
- *L* document which may throw doubts on priority claim(s) or which is cited to establish the publication date of another citation or other special reason (as specified)
- *O* document referring to an oral disclosure, use, exhibition or other means
- *P* document published prior to the international filing date but later than the priority date claimed

- *T* later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention
- *X* document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone
- *Y* document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art.
- * & * document member of the same patent family

Date of the actual completion of the international search

4 January 2011

Date of mailing of the international search report

18/01/2011

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Authorized officer

Compos, Fabien

INTERNATIONAL SEARCH REPORT

International application No.
PCT/US2010/052798

Box No. II Observations where certain claims were found unsearchable (Continuation of item 2 of first sheet)

This international search report has not been established in respect of certain claims under Article 17(2)(a) for the following reasons:

1. Claims Nos.: 28-30
because they relate to subject matter not required to be searched by this Authority, namely:
Rule 39.1(iv) PCT - Method for treatment of the human or animal body by surgery
2. Claims Nos.:
because they relate to parts of the international application that do not comply with the prescribed requirements to such an extent that no meaningful international search can be carried out, specifically:
3. Claims Nos.:
because they are dependent claims and are not drafted in accordance with the second and third sentences of Rule 6.4(a).

Box No. III Observations where unity of invention is lacking (Continuation of item 3 of first sheet)

This International Searching Authority found multiple inventions in this international application, as follows:

1. As all required additional search fees were timely paid by the applicant, this international search report covers all searchable claims.
2. As all searchable claims could be searched without effort justifying an additional fees, this Authority did not invite payment of additional fees.
3. As only some of the required additional search fees were timely paid by the applicant, this International search report covers only those claims for which fees were paid, specifically claims Nos.:
4. No required additional search fees were timely paid by the applicant. Consequently, this international search report is restricted to the invention first mentioned in the claims; it is covered by claims Nos.:

Remark on Protest

- The additional search fees were accompanied by the applicant's protest and, where applicable, the payment of a protest fee.
- The additional search fees were accompanied by the applicant's protest but the applicable protest fee was not paid within the time limit specified in the invitation.
- No protest accompanied the payment of additional search fees.

INTERNATIONAL SEARCH REPORT

Information on patent family members

International application No

PCT/US2010/052798

Patent document cited in search report	Publication date	Patent family member(s)	Publication date
US 2008017195	A1	24-01-2008	NONE
US 2005279363	A1	22-12-2005	WO 2006002279 A1
			05-01-2006