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Tenger et al.

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(54) **LARYNGOSCOPE AND METHOD OF USE**

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John R. Hicks, Carlsbad, CA (US)

(73) Assignee: **Salter Labs**, Lake Forest, IL (US)

(21) Appl. No.: **15/474,974**

(22) Filed: **Mar. 30, 2017**

Related U.S. Patent Documents

Reissue of:

(64) Patent No.: **9,072,446**
Issued: **Jul. 7, 2015**
Appl. No.: **13/328,499**
Filed: **Dec. 16, 2011**

U.S. Applications:

(63) Continuation-in-part of application No. 13/290,792, filed on Nov. 7, 2011, now abandoned, which is a continuation of application No. 12/698,467, filed on Feb. 2, 2010, now Pat. No. 8,152,719, which is a continuation-in-part of application No. 29/346,594, filed on Nov. 3, 2009, now Pat. No. Des. 632,787, and a continuation-in-part of application No. 12/368,952, filed on Feb. 10, 2009, now abandoned, which is a continuation-in-part of application No. 12/173,961,
(Continued)

(51) **Int. Cl.**
A61B 1/04 (2006.01)
A61B 1/06 (2006.01)
A61B 1/267 (2006.01)
A61M 16/04 (2006.01)

(52) **U.S. Cl.**
CPC **A61B 1/043** (2013.01); **A61B 1/0638** (2013.01); **A61B 1/0676** (2013.01); **A61B 1/0684** (2013.01); **A61B 1/2673** (2013.01); **A61M 16/04** (2013.01)

(58) **Field of Classification Search**

CPC **A61B 1/043**; **A61B 1/0638**; **A61B 1/0676**;
A61B 1/0684; **A61B 1/2673**
USPC **600/184-249**; **385/115-117**
See application file for complete search history.

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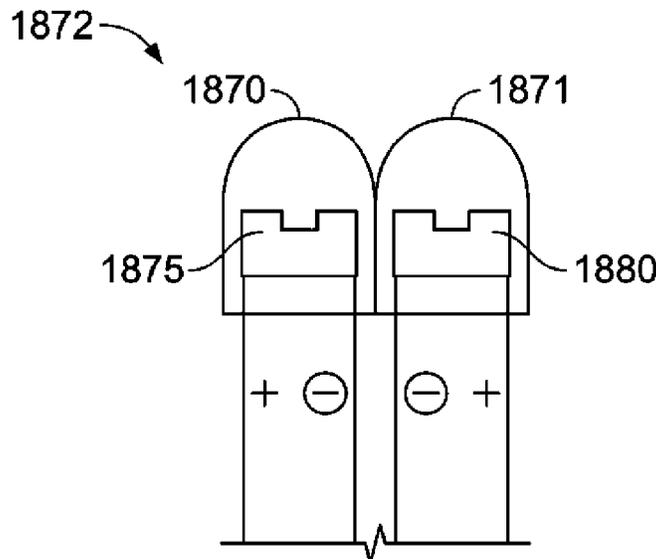
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Primary Examiner — Beverly M. Flanagan
(74) *Attorney, Agent, or Firm* — Procopio Cory Hargreaves and Savitch LLP

(57) **ABSTRACT**

A laryngoscope device for use in the performance of direct laryngoscopy, the device including a laryngoscope blade portion connectable to a laryngoscope handle through a connector, the laryngoscope blade comprising an ultraviolet light, a white light and an imaging or viewing device at the same distance relative to the distal end of the laryngoscope blade.

25 Claims, 53 Drawing Sheets



Related U.S. Application Data

filed on Jul. 16, 2008, now Pat. No. 8,012,087, which is a continuation-in-part of application No. 12/144,147, filed on Jun. 23, 2008, now Pat. No. 8,257,250.

(60) Provisional application No. 61/288,779, filed on Dec. 21, 2009.

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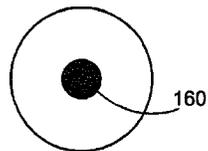
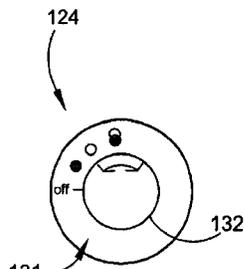
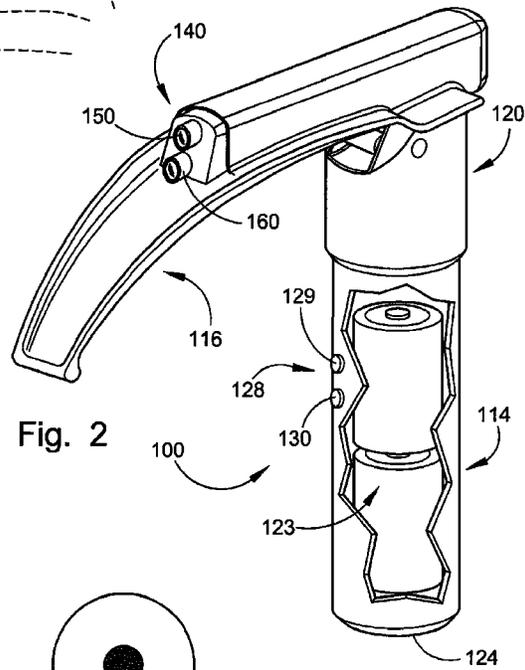
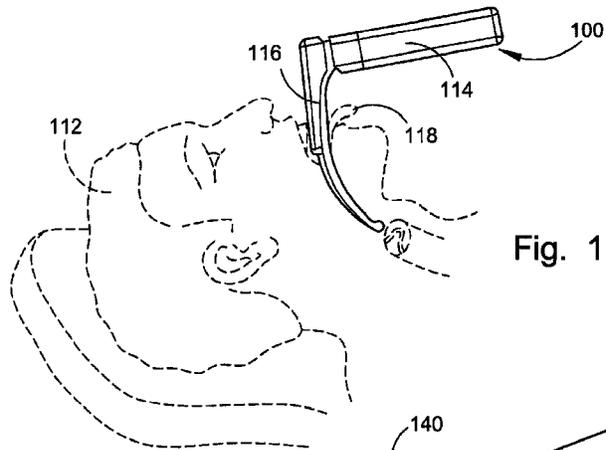
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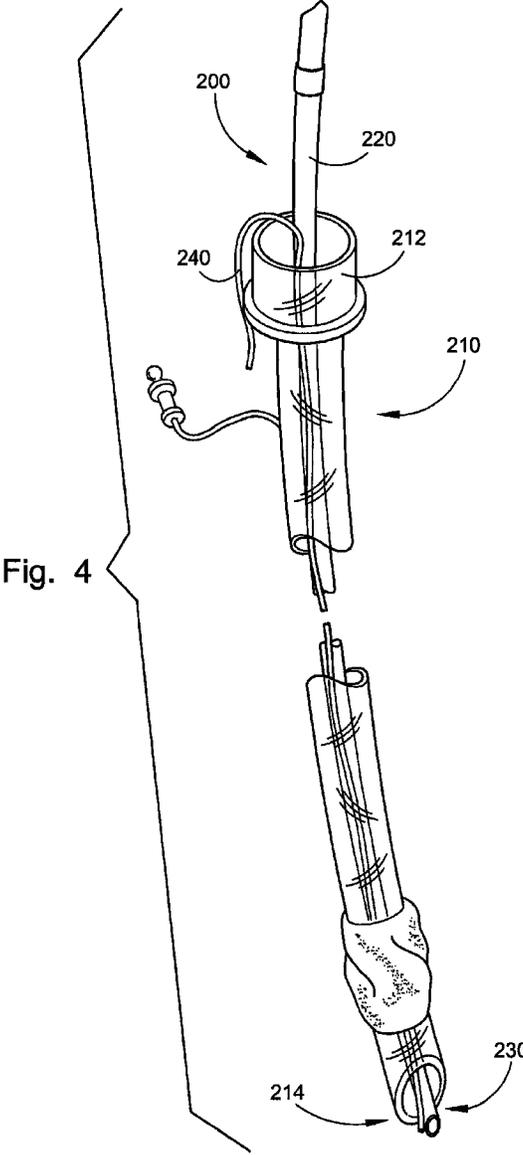
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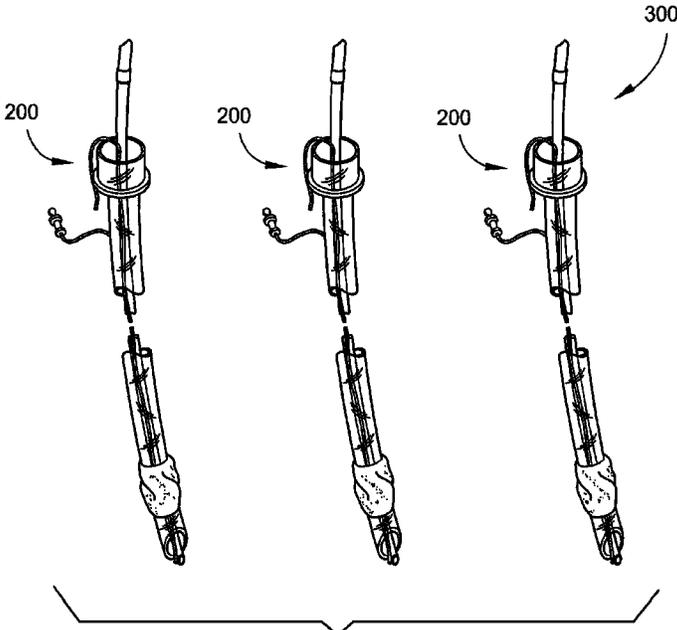


Fig. 5

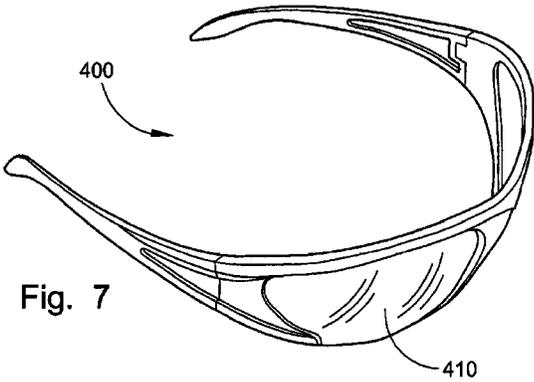


Fig. 7

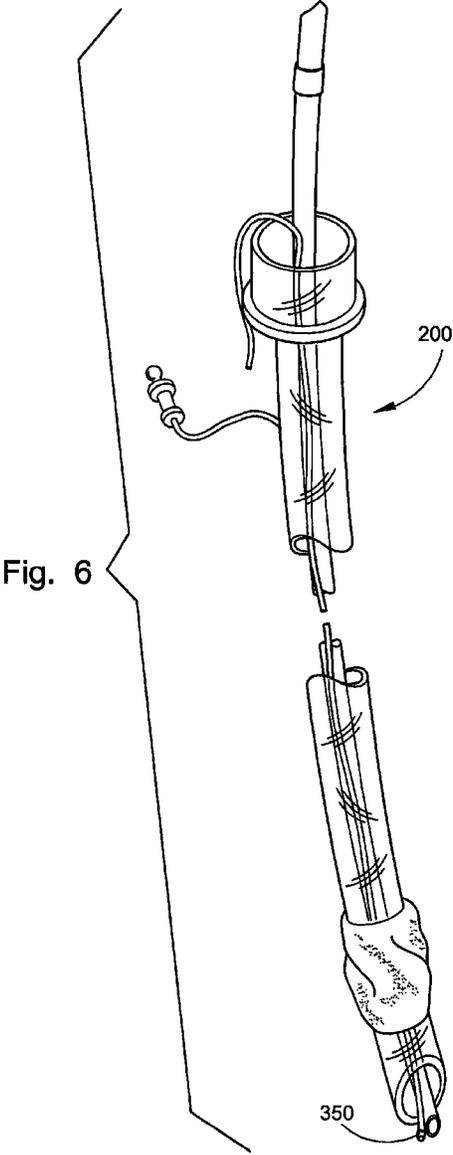
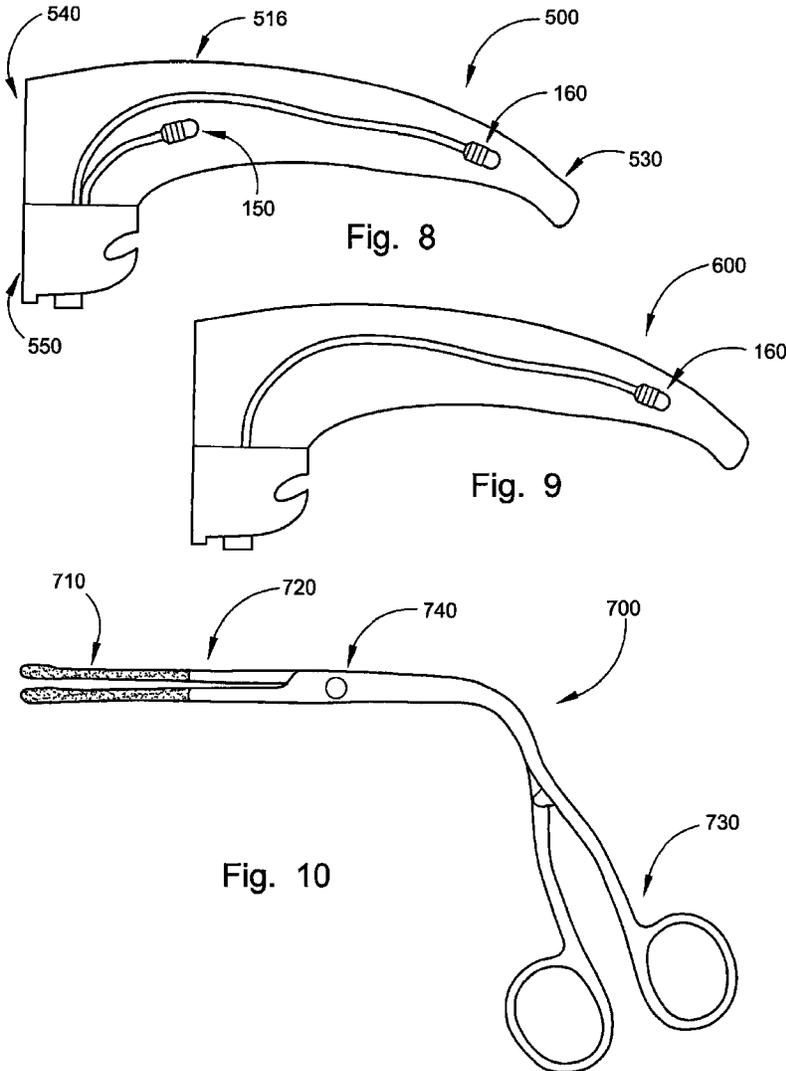


Fig. 6



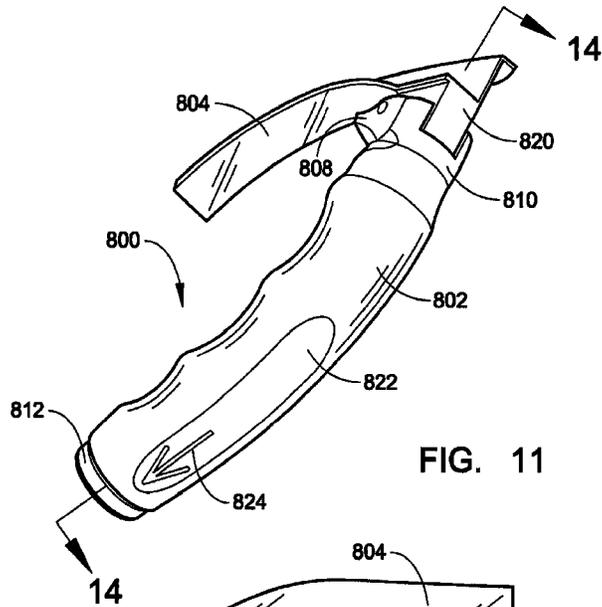


FIG. 11

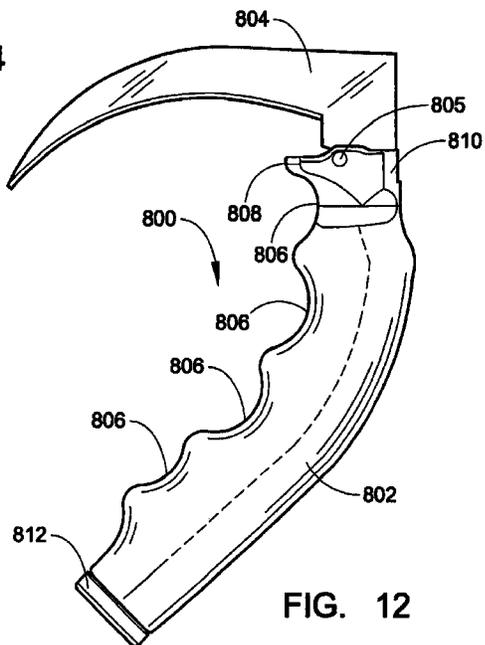


FIG. 12

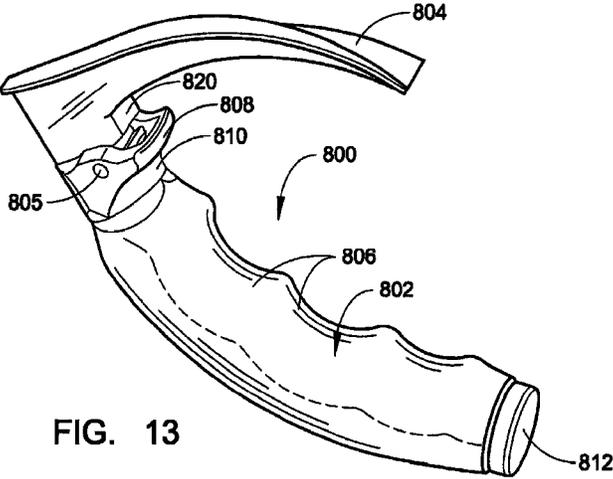


FIG. 13

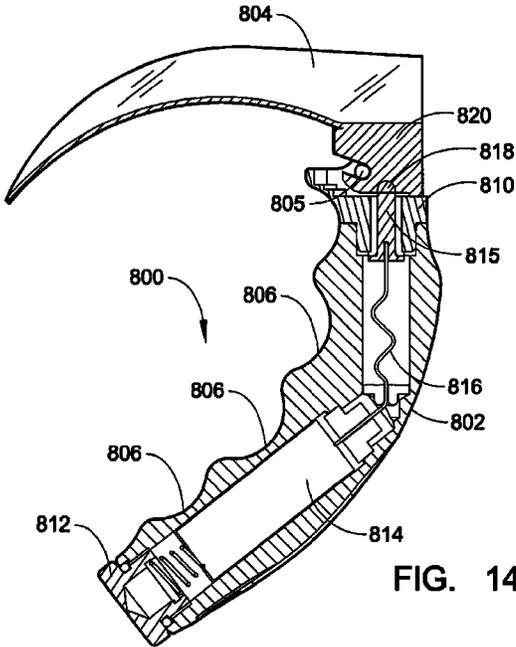


FIG. 14

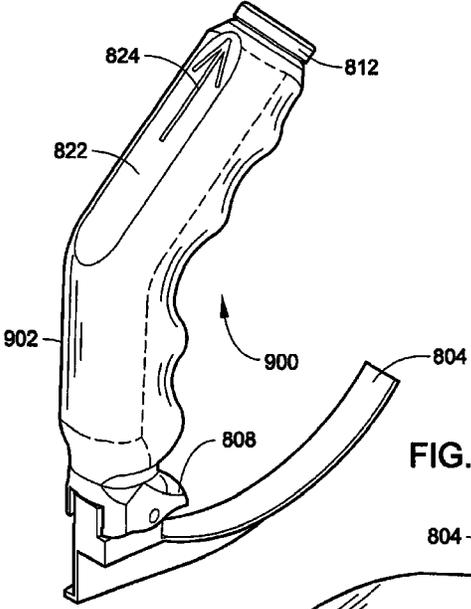


FIG. 15

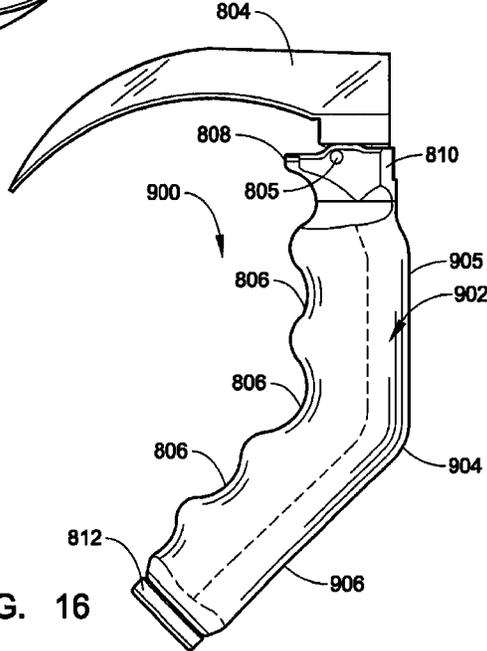
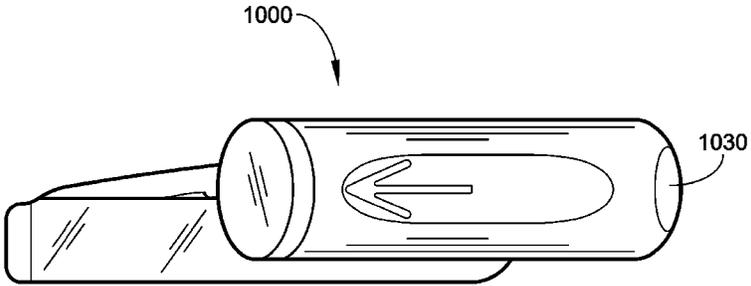
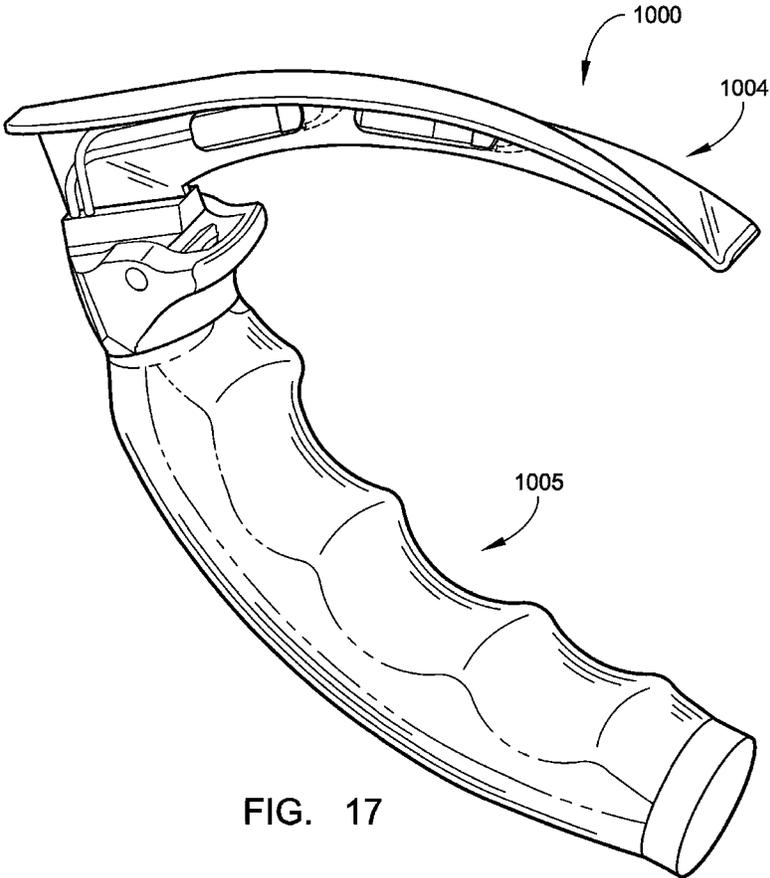
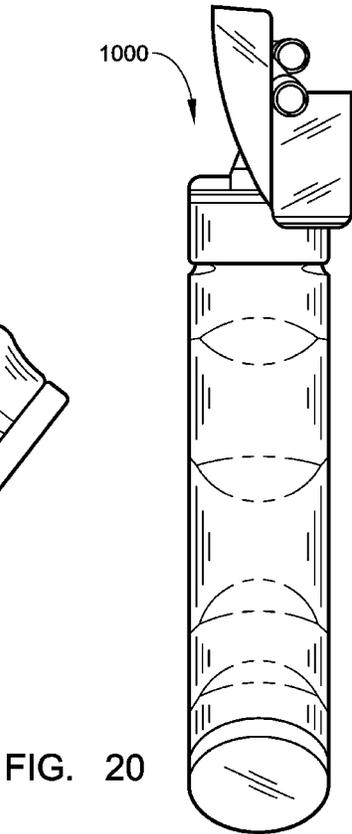
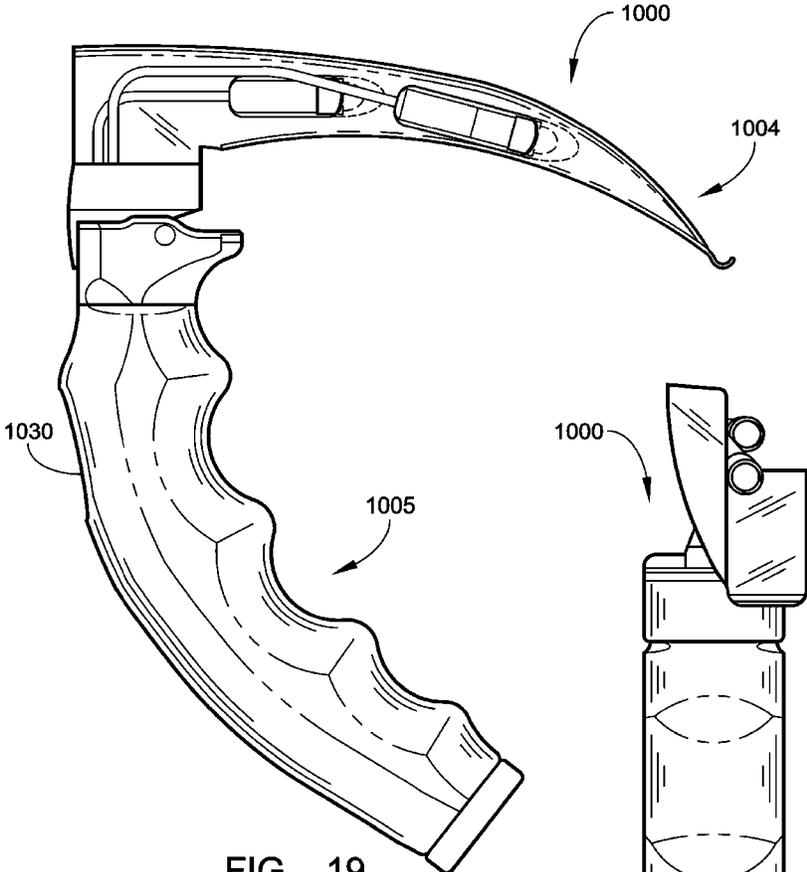
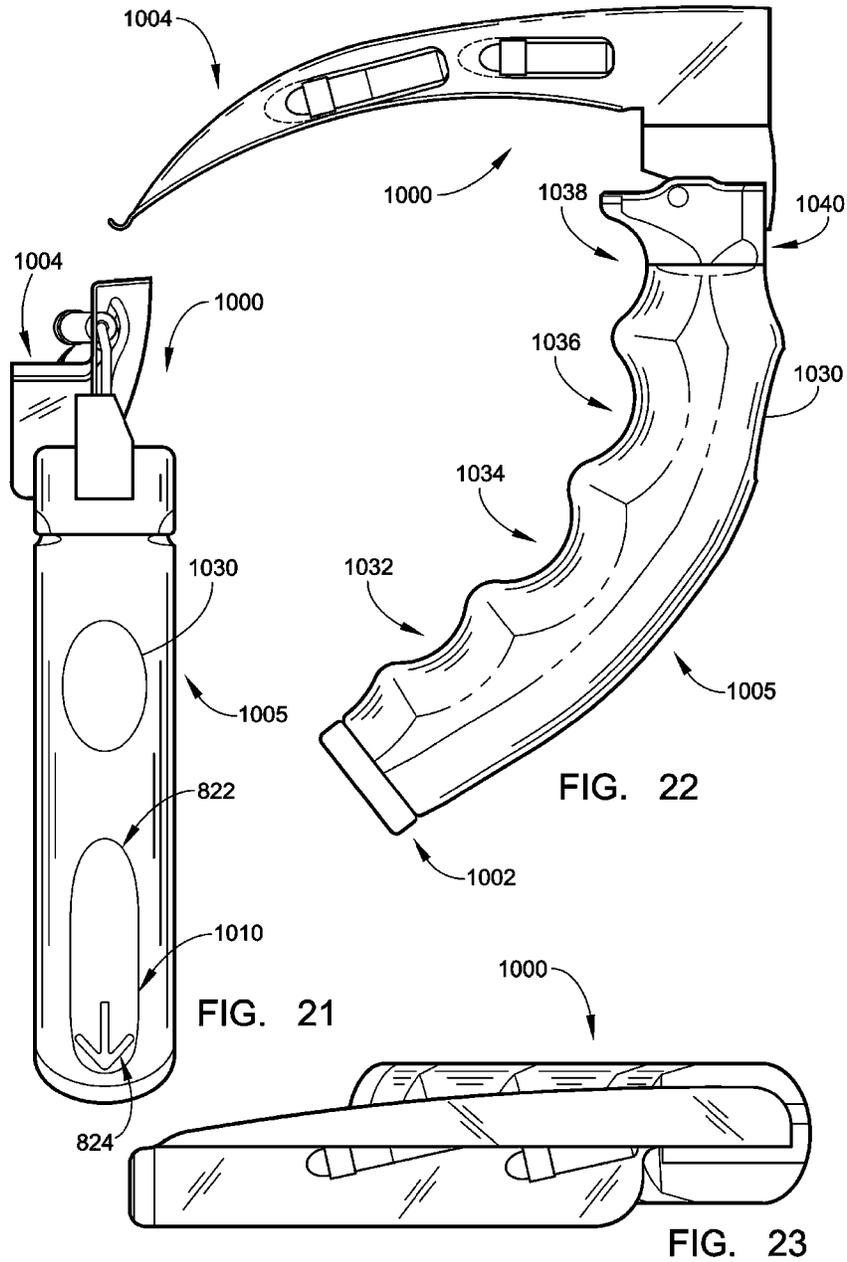


FIG. 16







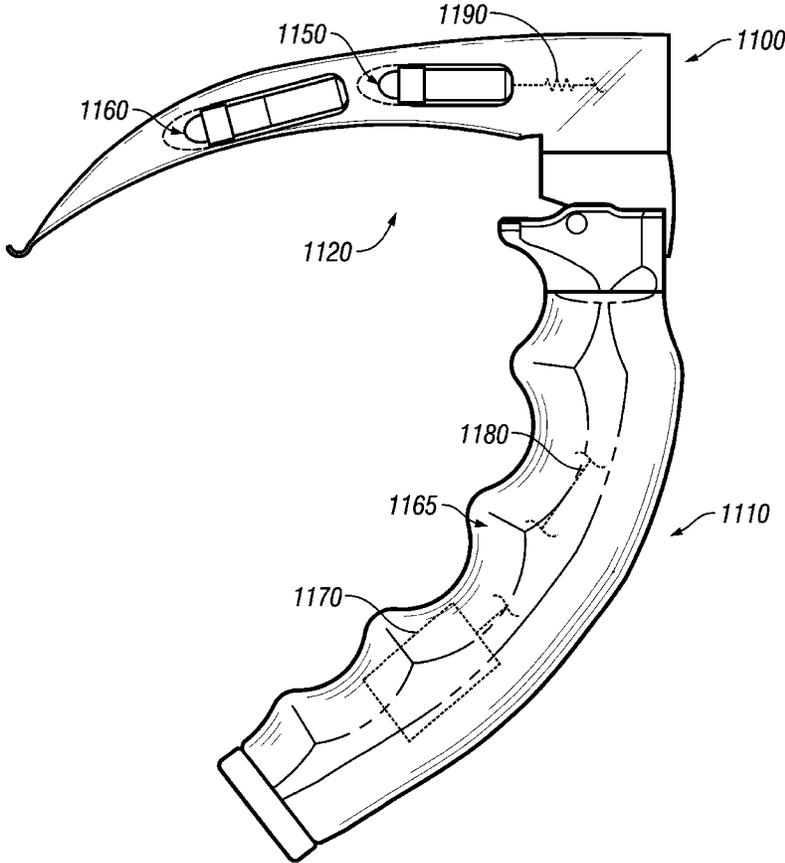


FIG. 24

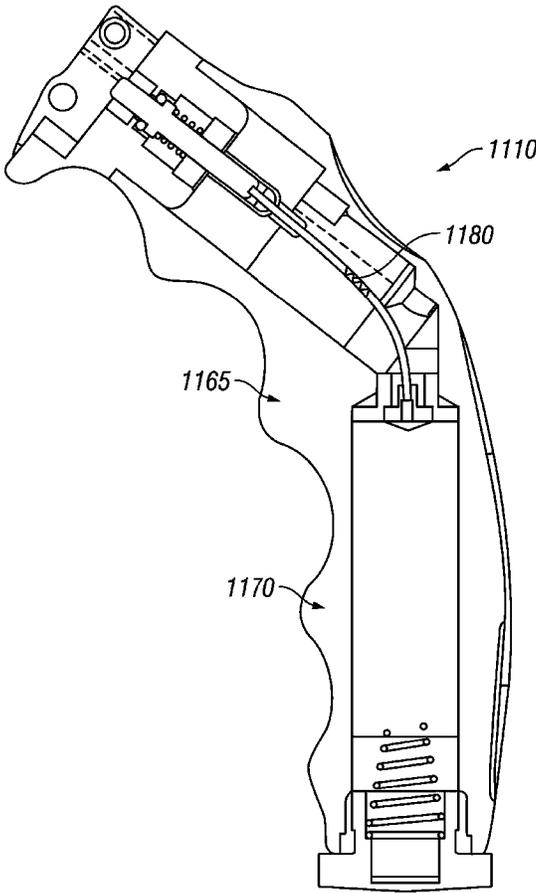


FIG. 25

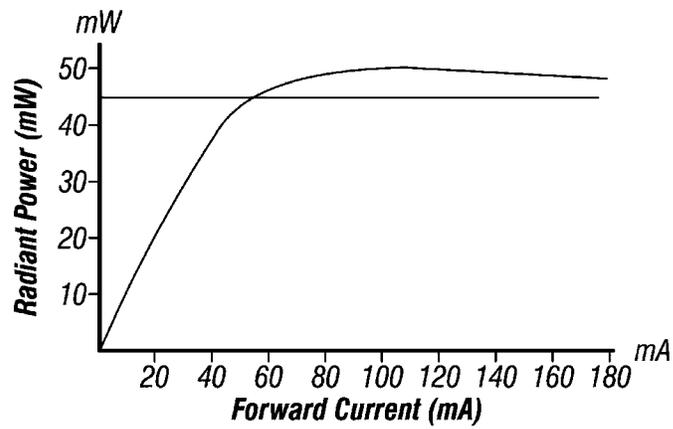


FIG. 26

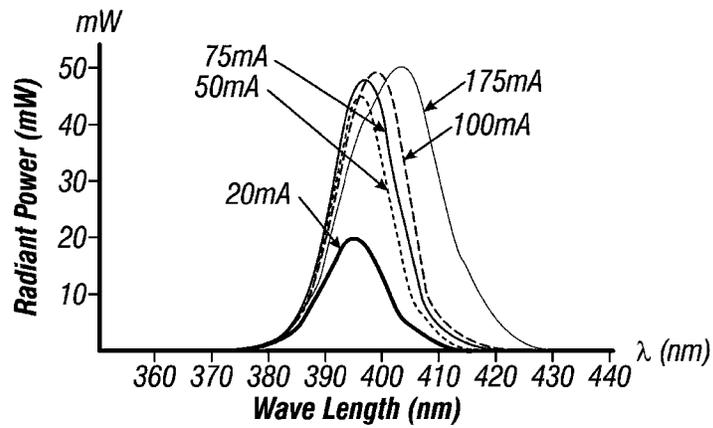


FIG. 27

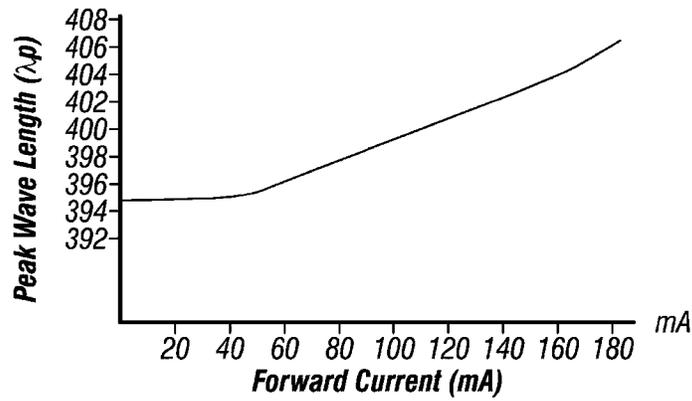


FIG. 28

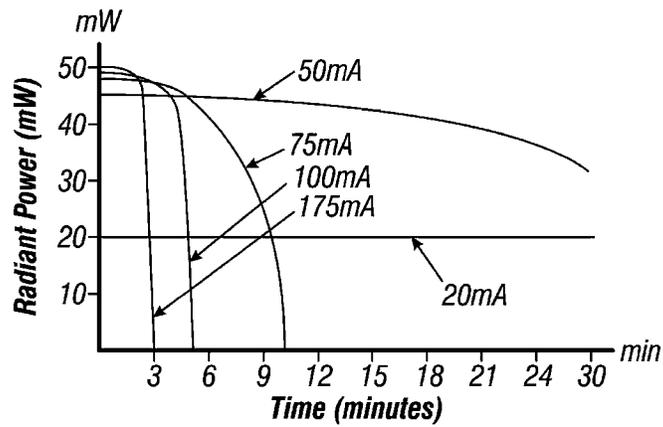


FIG. 29

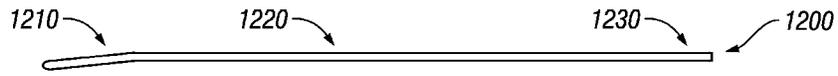


FIG. 30

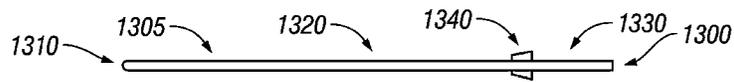


FIG. 31



FIG. 32A

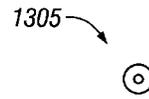


FIG. 32B

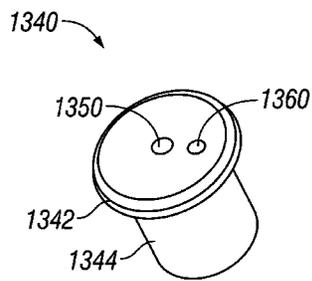


FIG. 33A

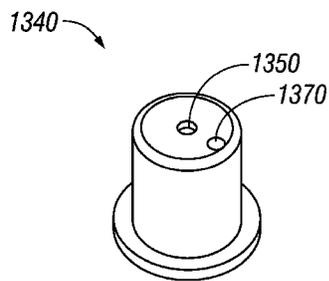


FIG. 33B

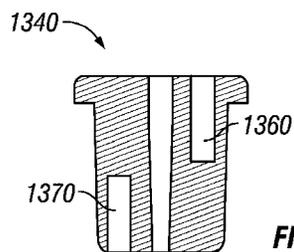


FIG. 33C

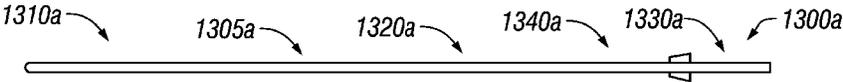


FIG. 34



FIG. 35A

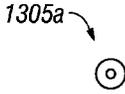


FIG. 35B

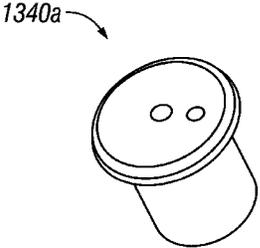


FIG. 36A

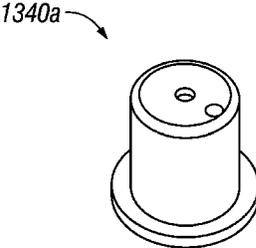


FIG. 36B

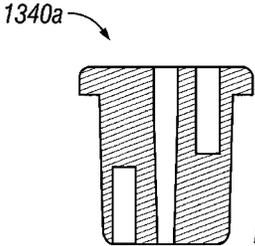


FIG. 36C

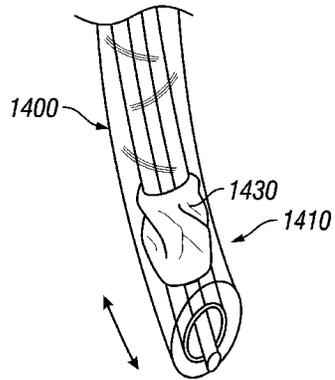


FIG. 37A

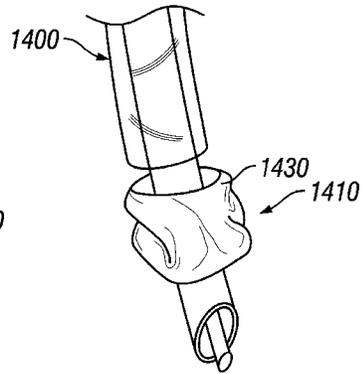


FIG. 37B

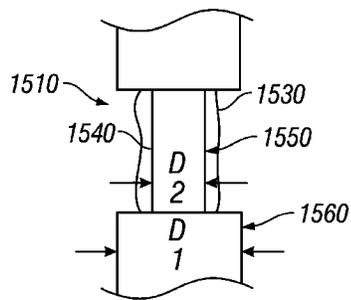


FIG. 38A

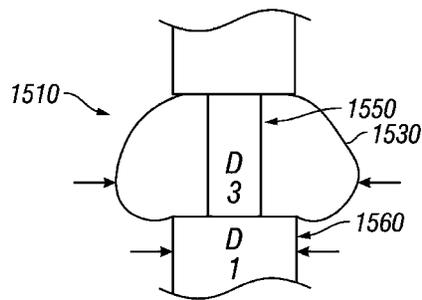


FIG. 38B

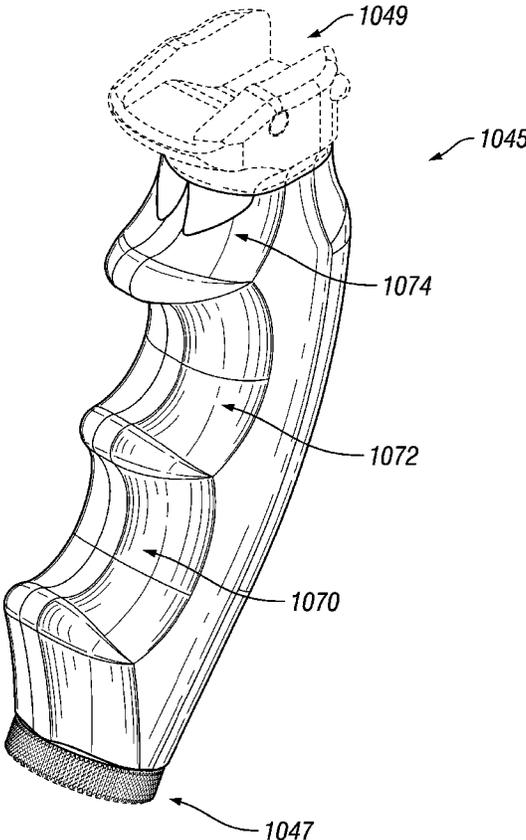


FIG. 39A

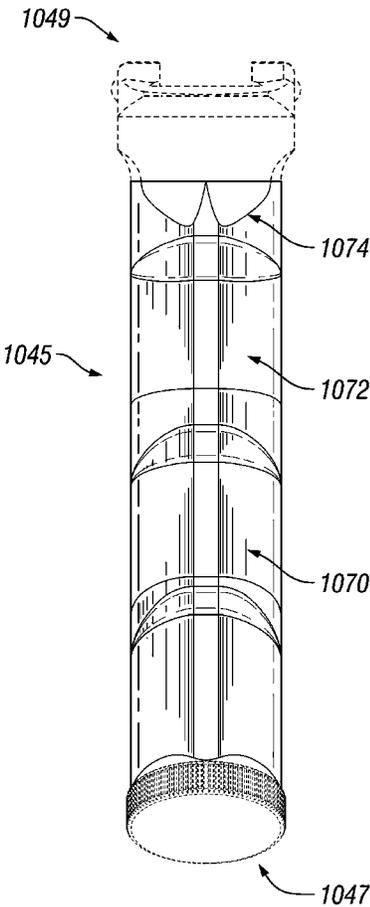


FIG. 39B

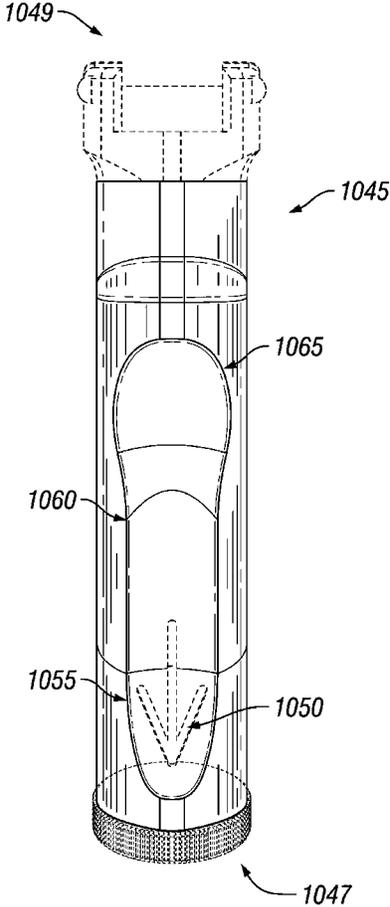


FIG. 39C

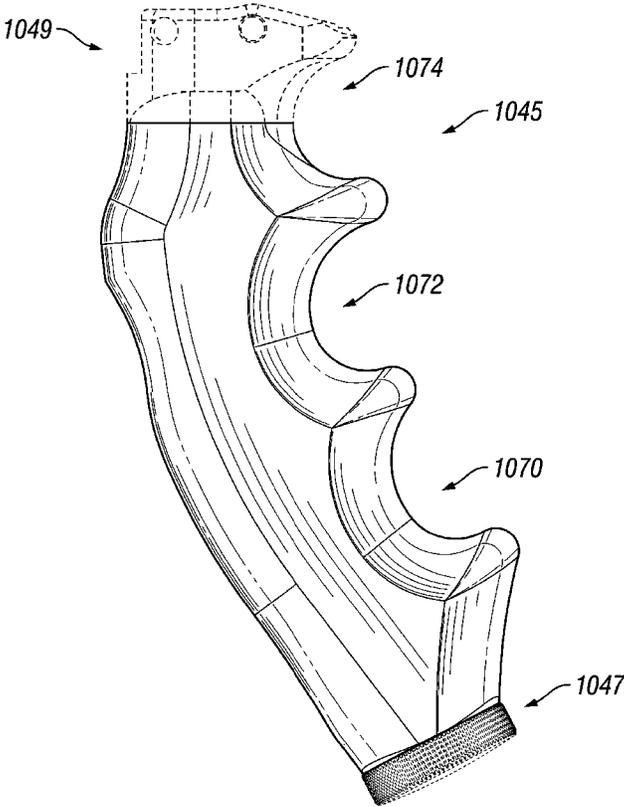


FIG. 39D

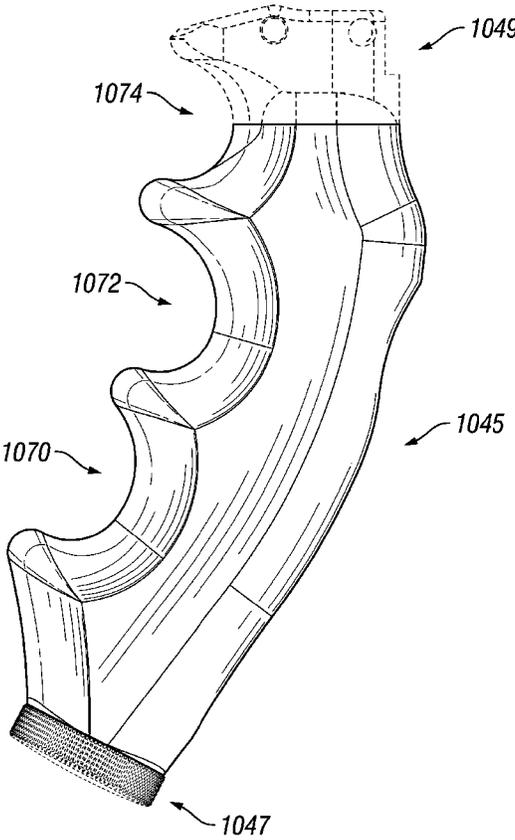


FIG. 39E

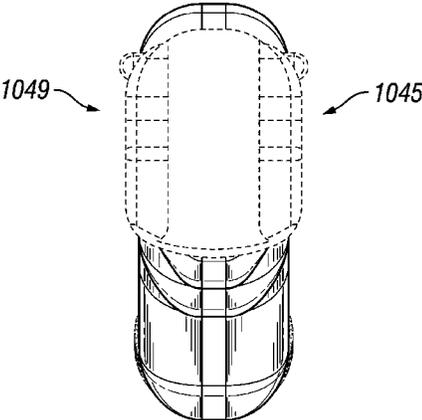


FIG. 39F

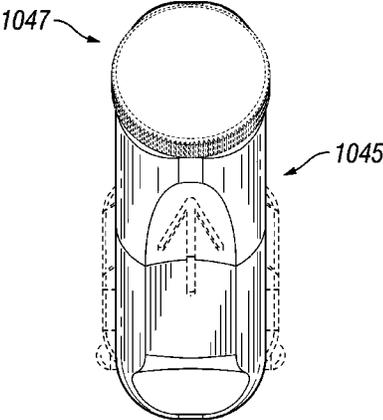


FIG. 39G

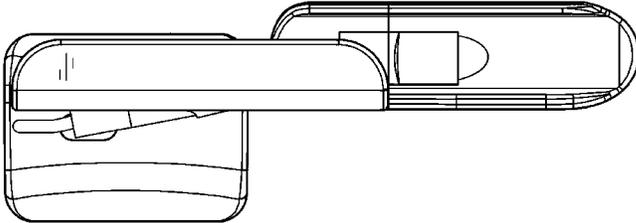


FIG. 40B

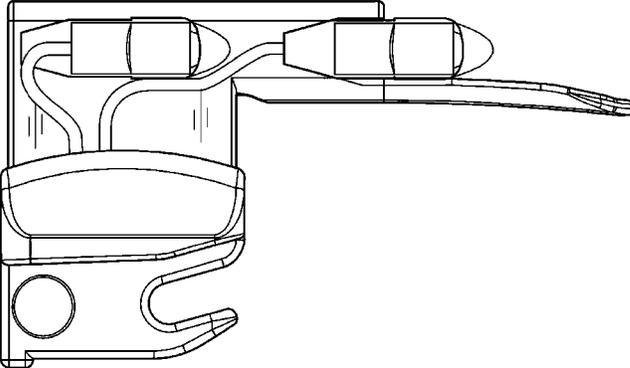


FIG. 40A

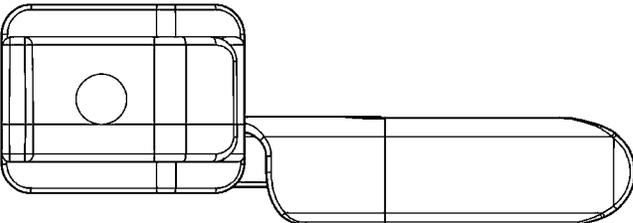


FIG. 40D

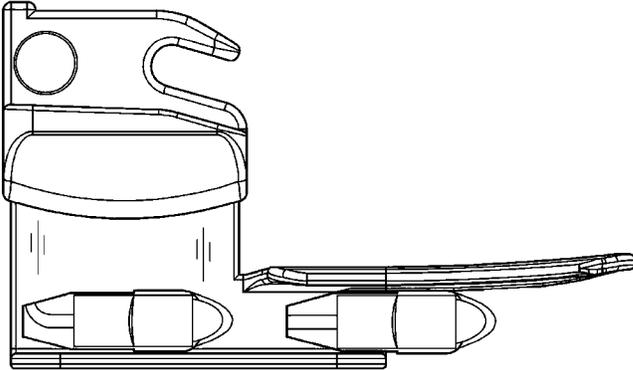


FIG. 40C

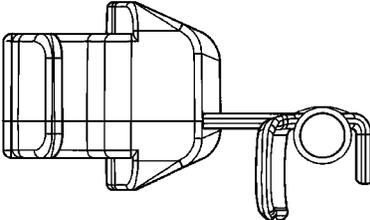


FIG. 40E

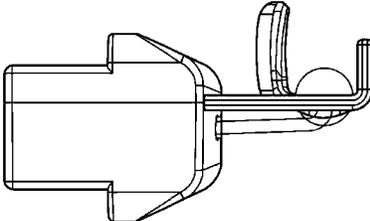


FIG. 40F

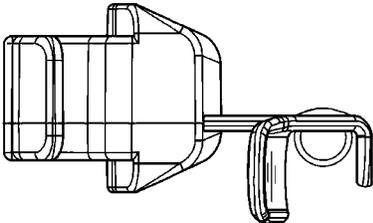


FIG. 41A

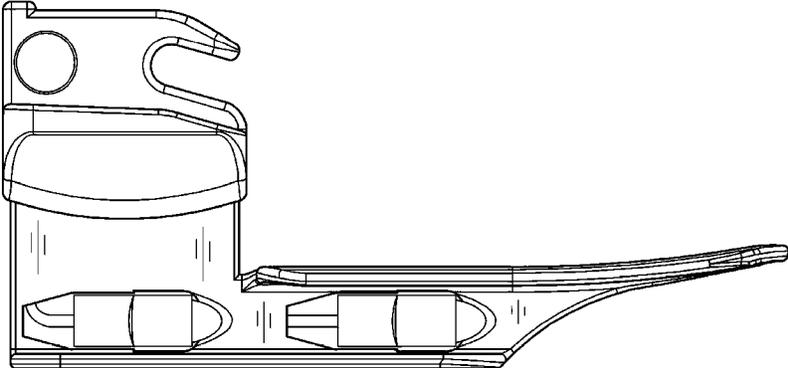


FIG. 41B

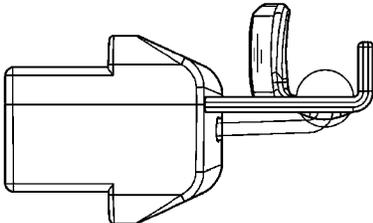


FIG. 41C

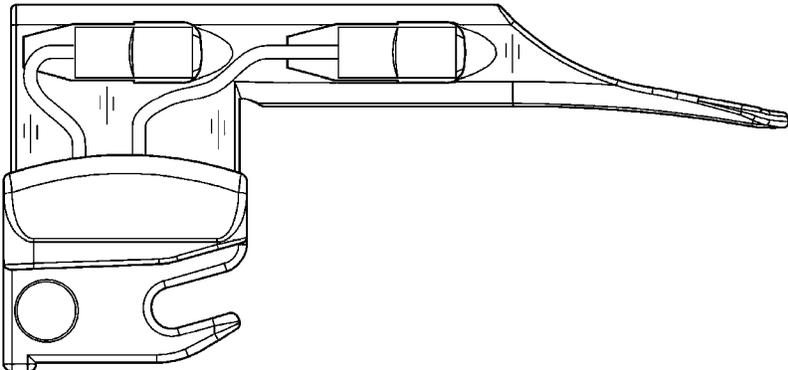


FIG. 41D

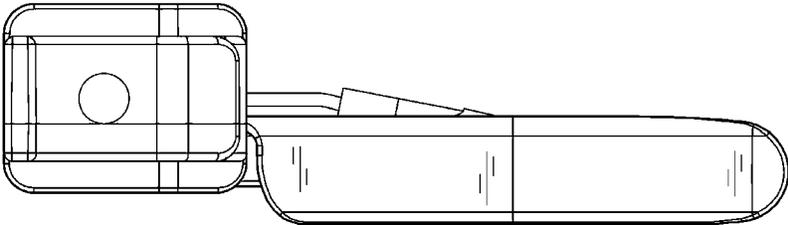


FIG. 41E

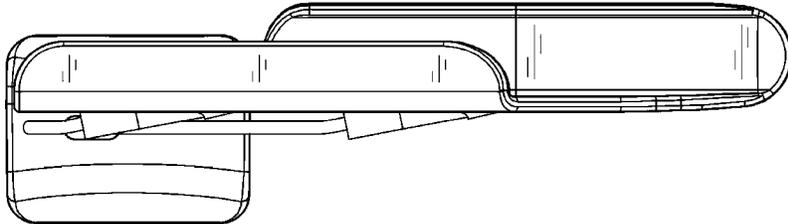


FIG. 41F

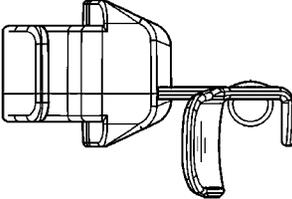


FIG. 42A

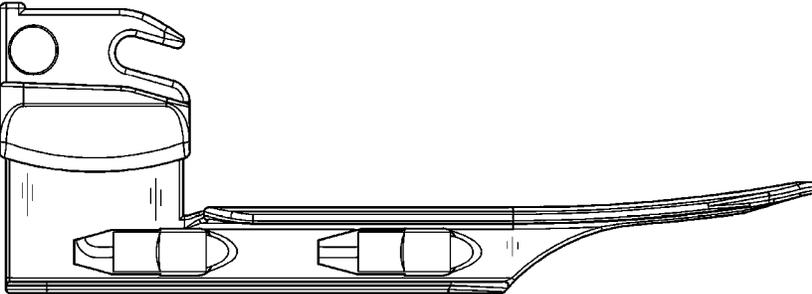


FIG. 42B

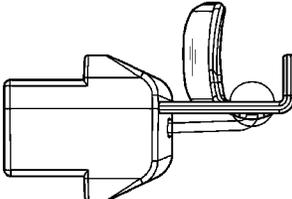


FIG. 42C

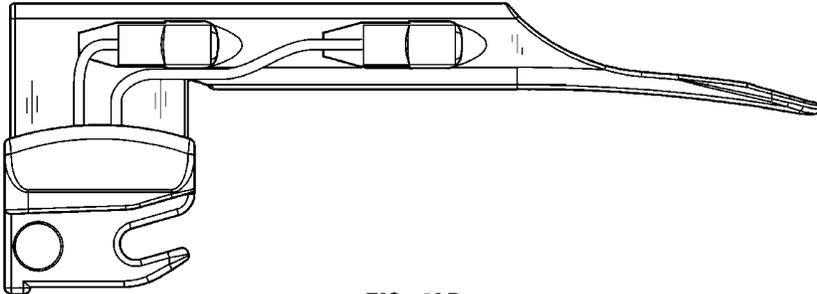


FIG. 42D

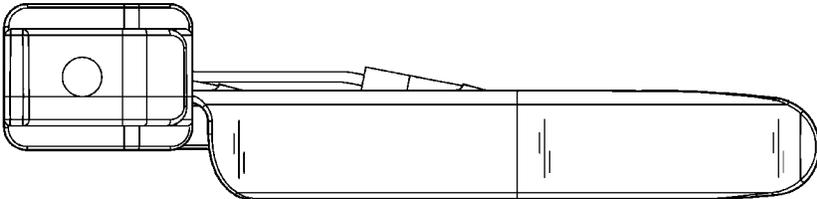


FIG. 42E

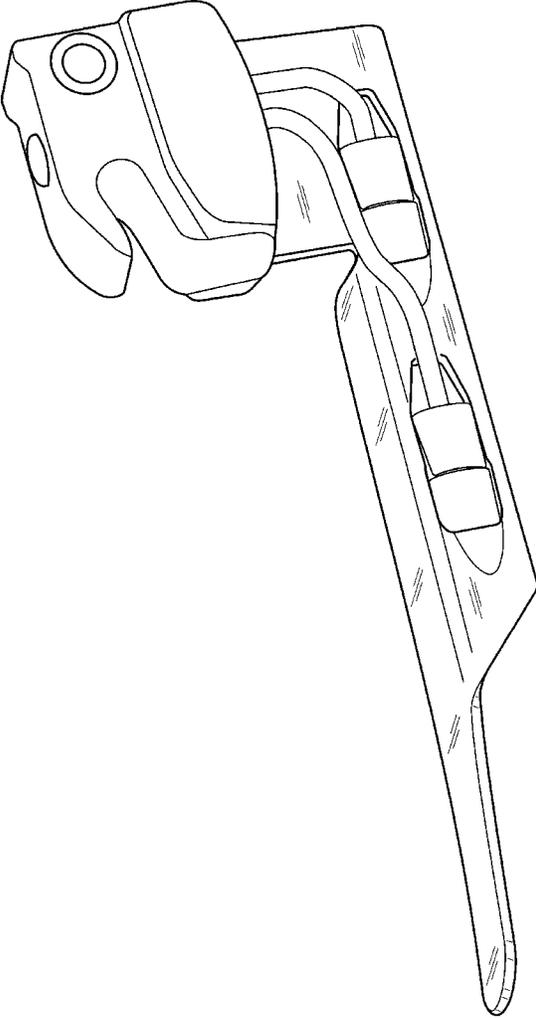


FIG. 42F

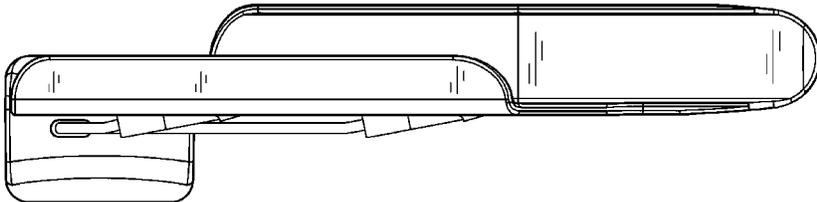


FIG. 42G

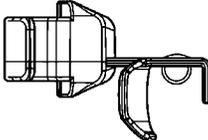


FIG. 43A

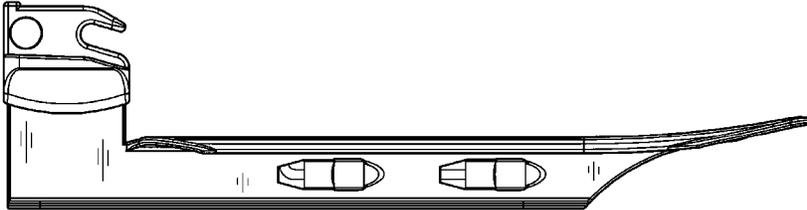


FIG. 43B

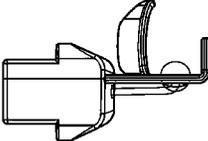


FIG. 43C

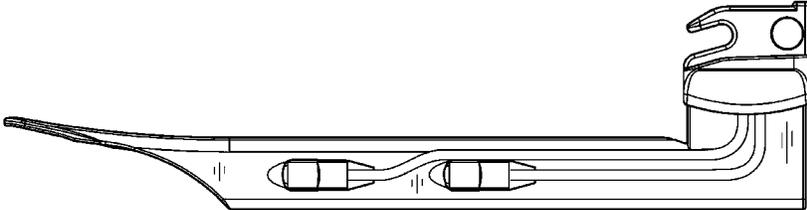


FIG. 43D

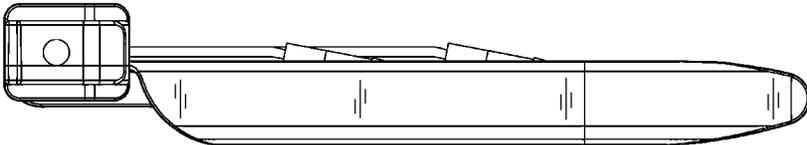


FIG. 43E



FIG. 43F

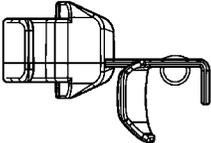


FIG. 44A

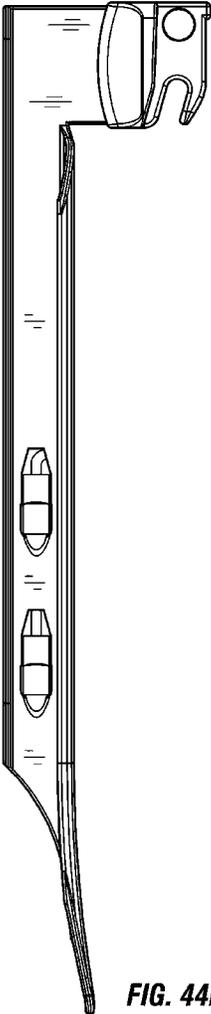


FIG. 44B

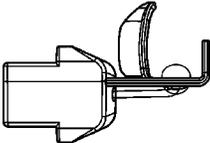


FIG. 44C

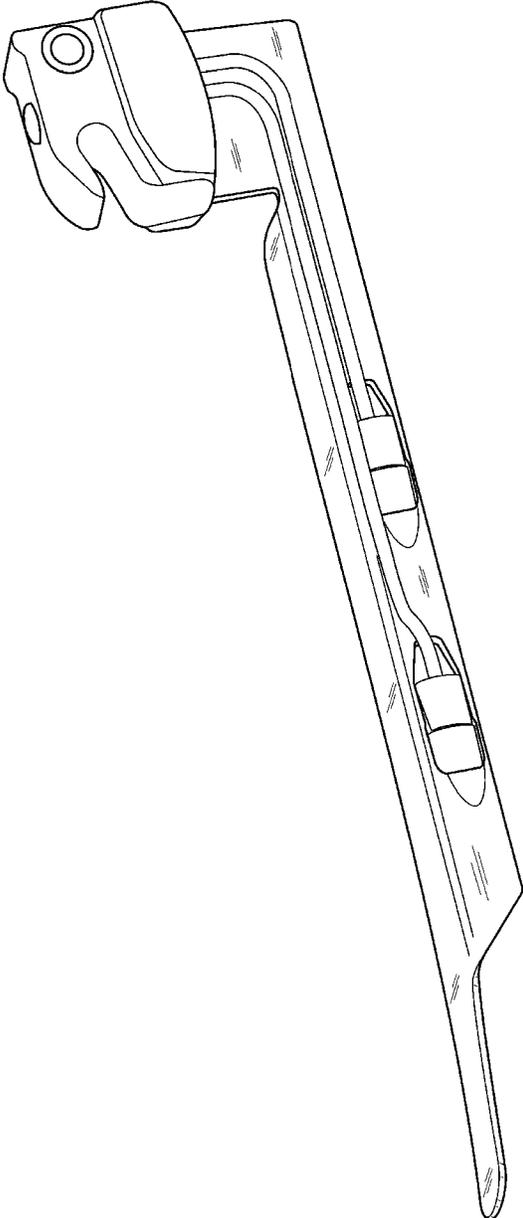


FIG. 44D

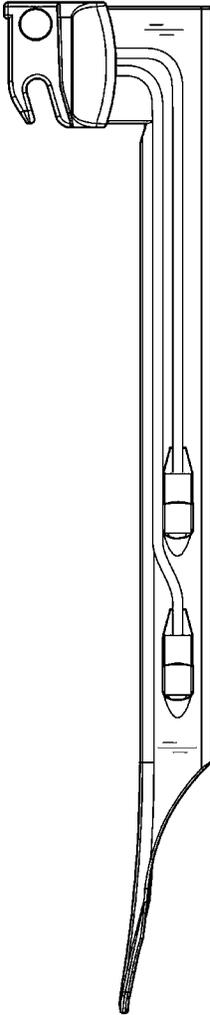


FIG. 44E

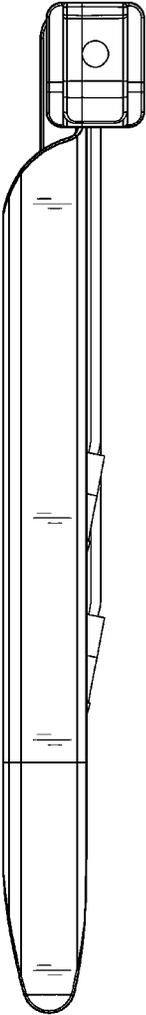


FIG. 44F

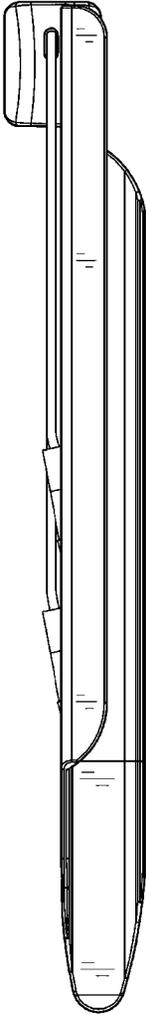


FIG. 44G

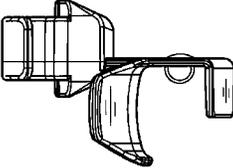


FIG. 45A

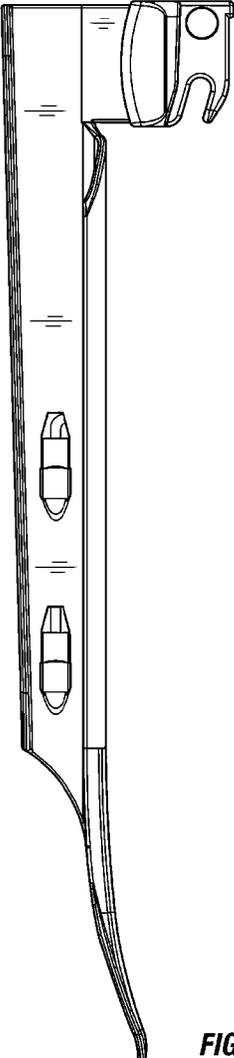


FIG. 45B

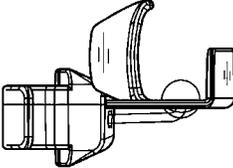


FIG. 45C

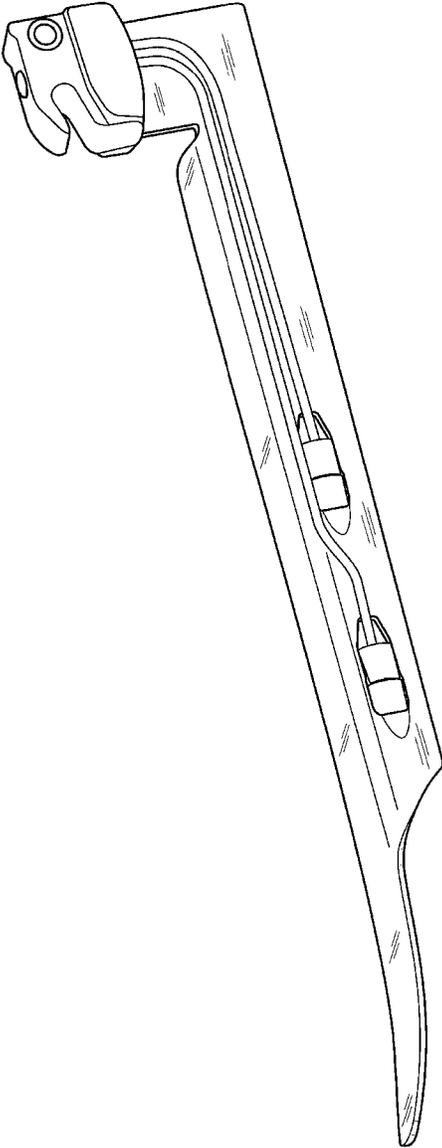


FIG. 45D

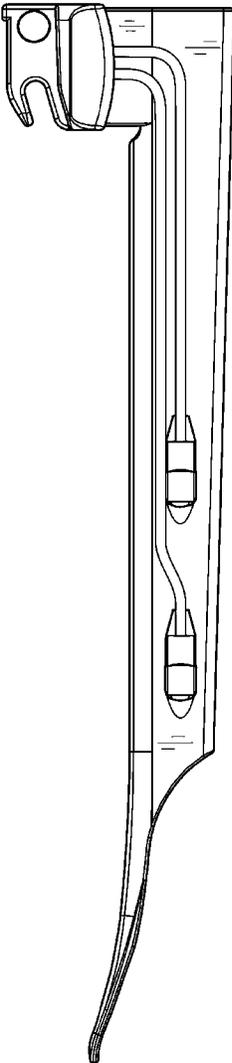


FIG. 45E

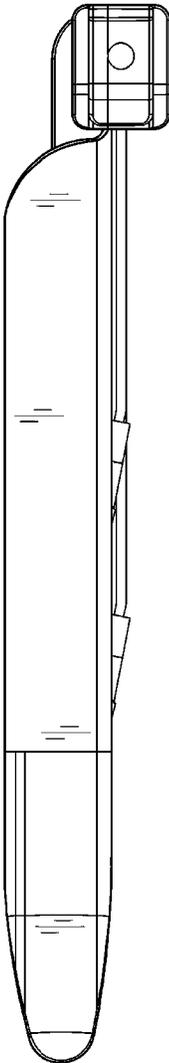


FIG. 45F

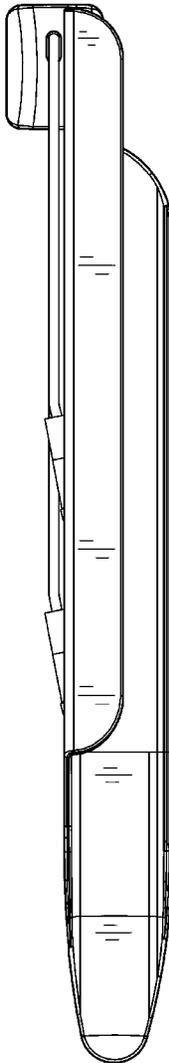


FIG. 45G

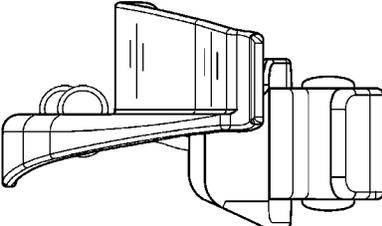


FIG. 46A

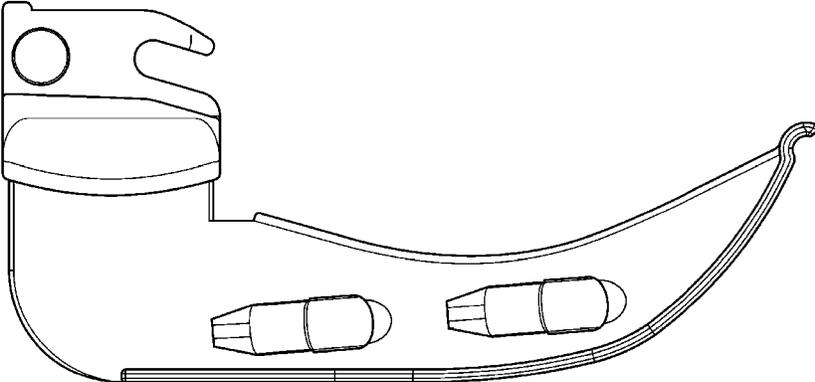


FIG. 46B

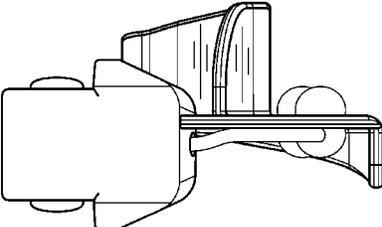


FIG. 46C

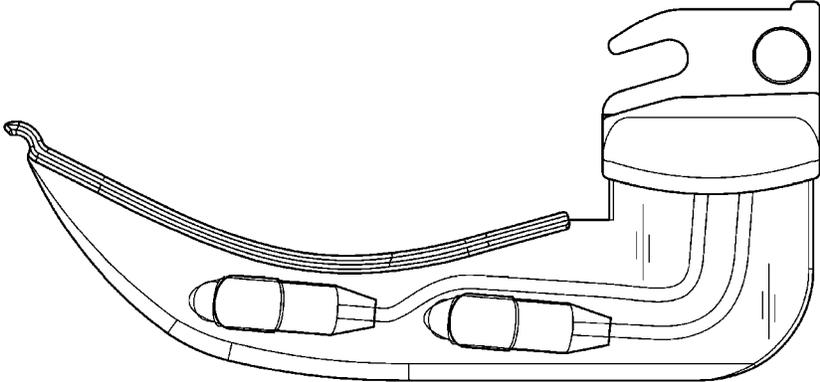


FIG. 46D

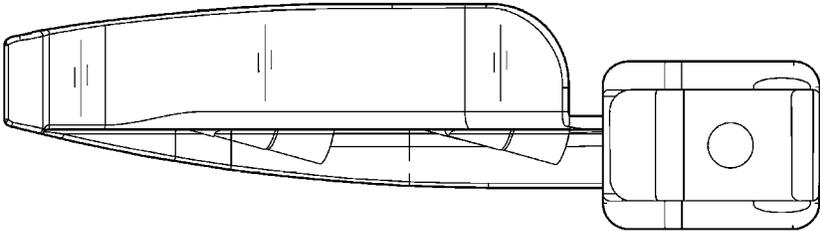


FIG. 46E

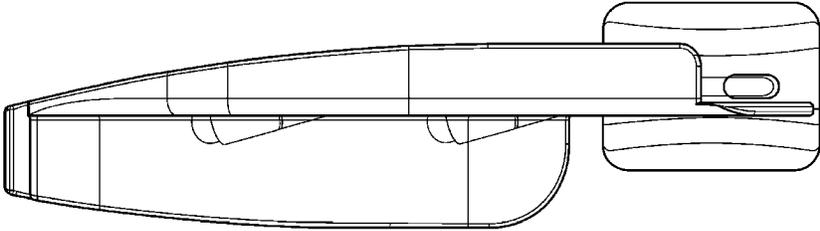


FIG. 46F

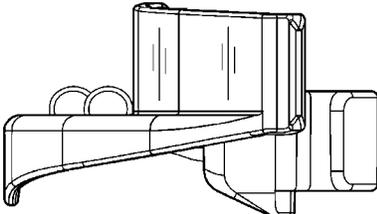


FIG. 47A

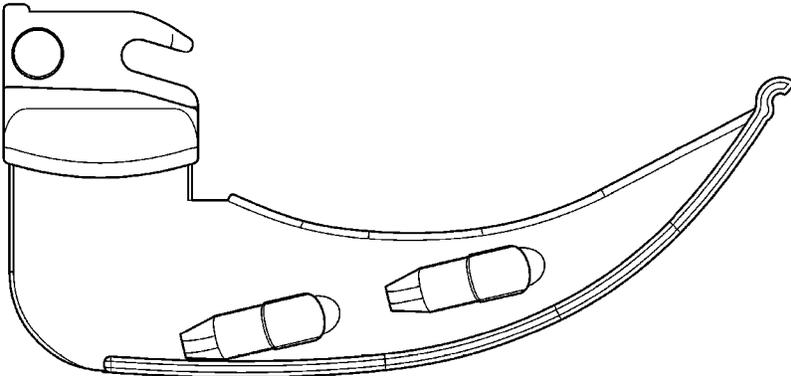


FIG. 47B

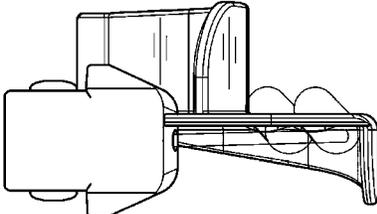


FIG. 47C

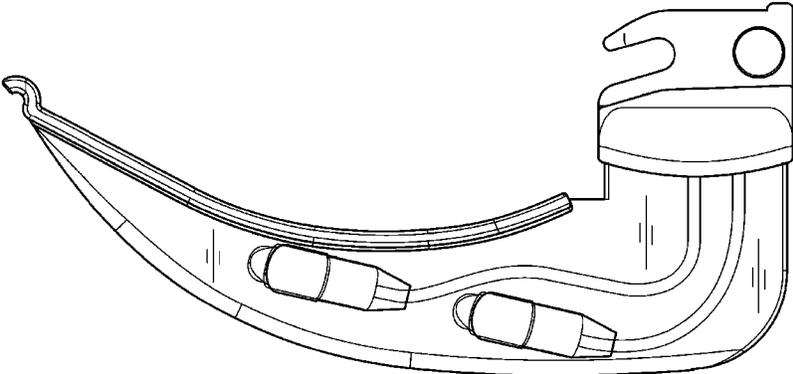


FIG. 47D

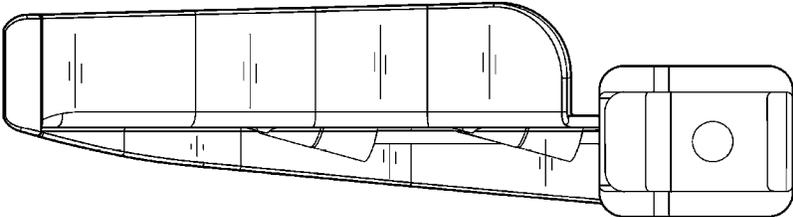


FIG. 47E

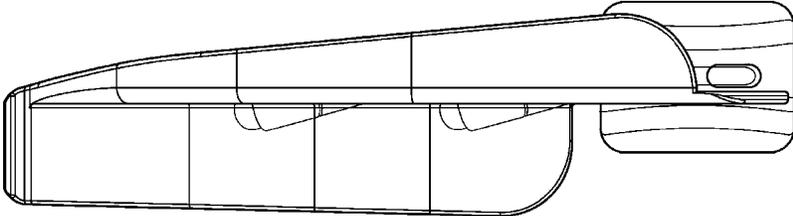


FIG. 47F

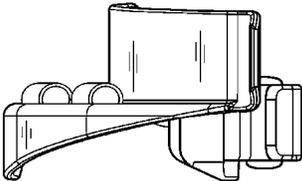


FIG. 48A

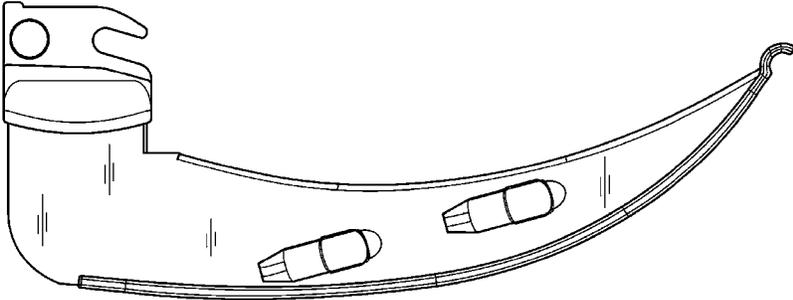


FIG. 48B

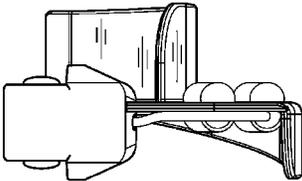


FIG. 48C

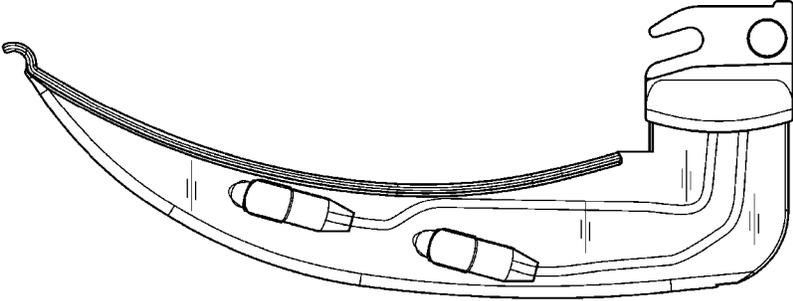


FIG. 48D

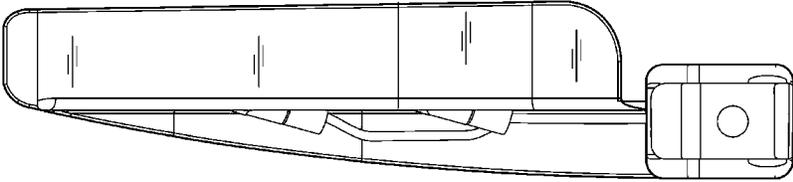


FIG. 48E

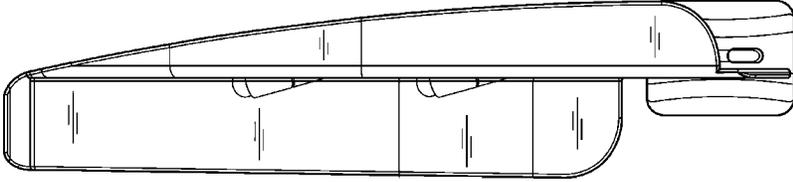


FIG. 48F

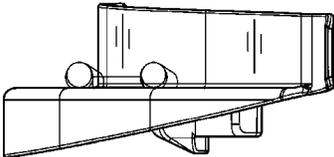


FIG. 49A

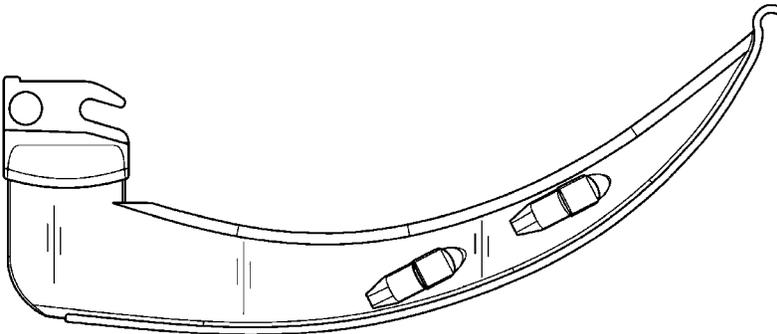


FIG. 49B

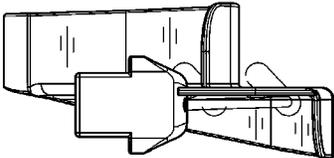


FIG. 49C

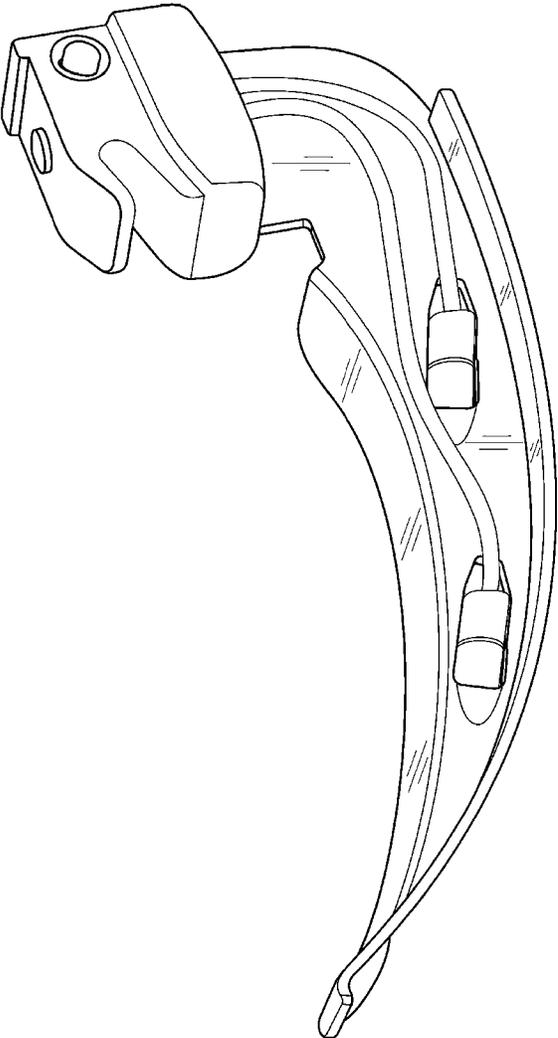


FIG. 49D

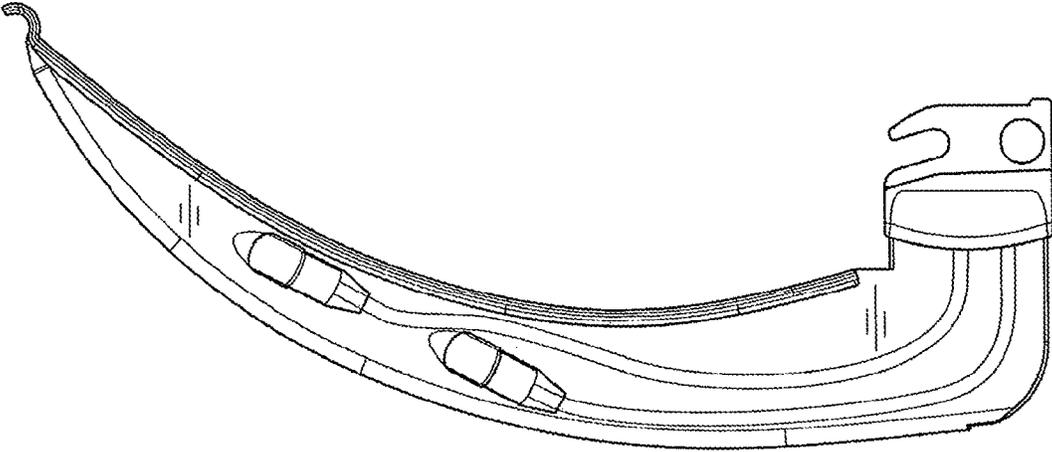


FIG. 49E

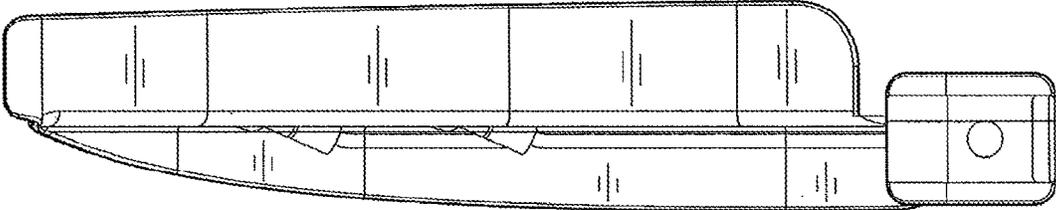


FIG. 49F

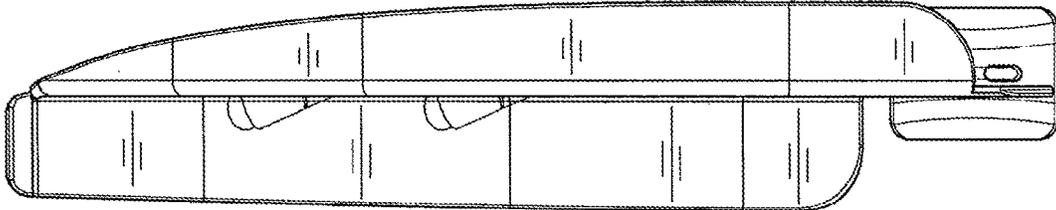


FIG. 49G

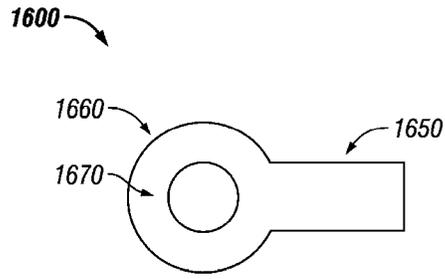


FIG. 50A

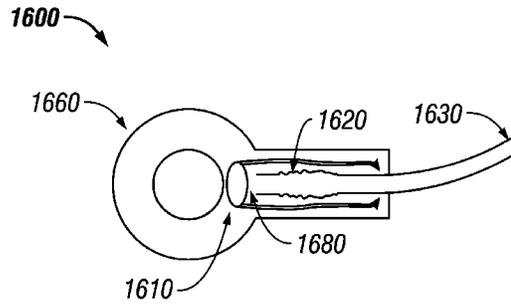


FIG. 50B

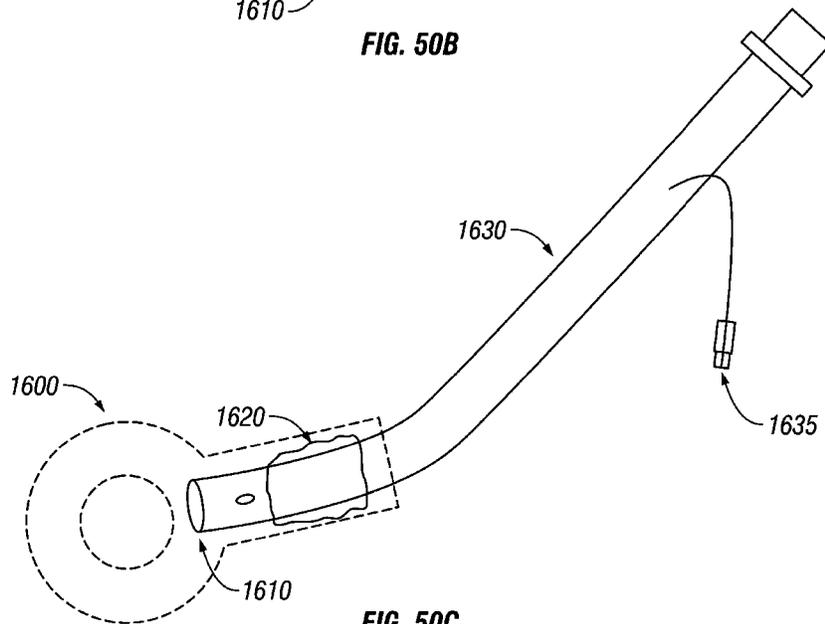


FIG. 50C

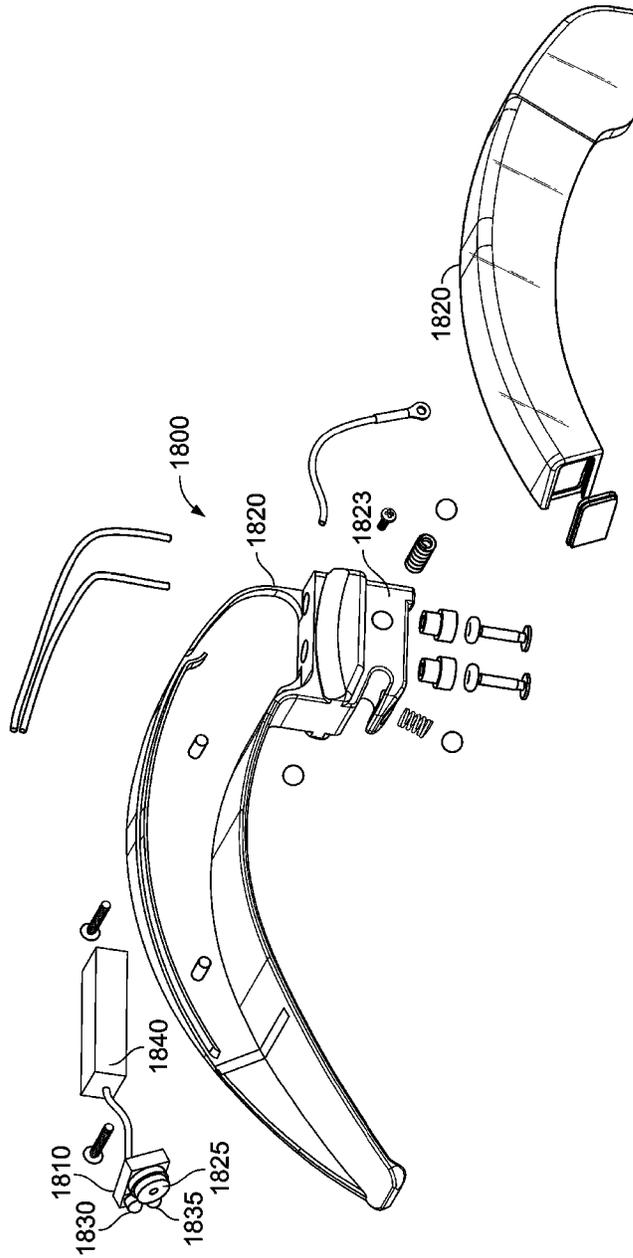


FIG. 51

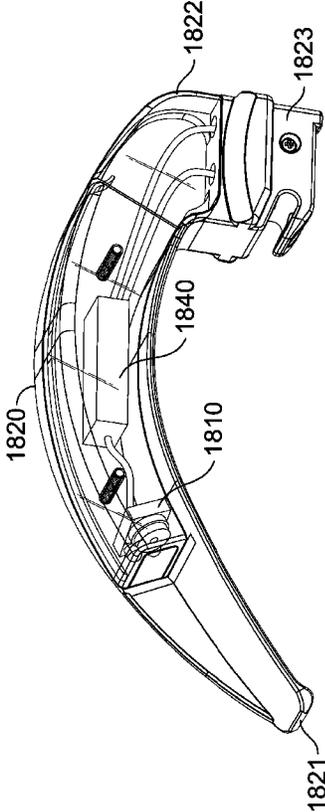


FIG. 52

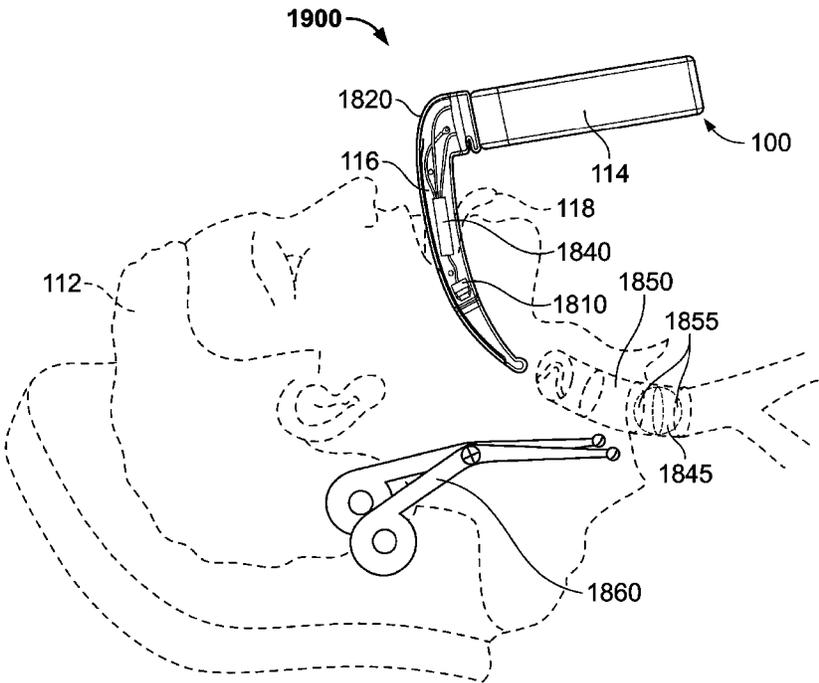


FIG. 53

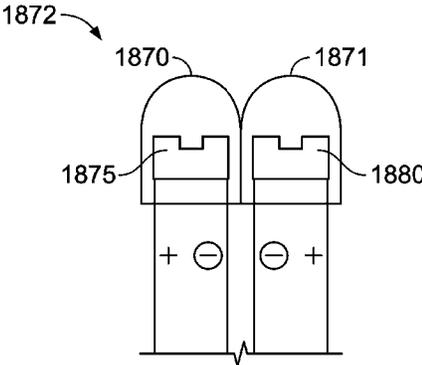


FIG. 54

LARYNGOSCOPE AND METHOD OF USE

Matter enclosed in heavy brackets [] appears in the original patent but forms no part of this reissue specification; matter printed in italics indicates the additions made by reissue; a claim printed with strikethrough indicates that the claim was canceled, disclaimed, or held invalid by a prior post-patent action or proceeding.

CROSS-REFERENCE TO RELATED APPLICATIONS

This application is a continuation-in-part of U.S. patent application Ser. No. 13/290,792, filed on Nov. 7, 2011, which is a continuation of U.S. patent application Ser. No. 12/698,467, filed Feb. 2, 2010, which is a continuation-in-part of U.S. patent application Ser. No. 29/346,594, filed Nov. 3, 2009, now U.S. Des. Pat. No. D632,787, and is a continuation-in-part of U.S. patent application Ser. No. 12/368,952, filed Feb. 10, 2009, now abandoned, which is a continuation-in-part of U.S. patent application Ser. No. 12/173,961, filed on Jul. 16, 2008, now U.S. Pat. No. 8,012,087, which is a continuation-in-part of U.S. patent application Ser. No. 12/144,147, filed Jun. 23, 2008. This application also claims priority under 35 U.S.C. 119(e) to U.S. Provisional Patent Application No. 61/288,779, filed Dec. 21, 2009. The contents of each and all of the above patent applications are incorporated herein by reference in their entirety.

FIELD OF THE INVENTION

The field of this invention relates to laryngoscopes and the laryngoscopy procedure.

BACKGROUND OF THE INVENTION

Health care providers perform direct laryngoscopy to either clear a patient's airway of debris, or place an endotracheal tube into a patient's trachea to assist or replace a patient's ability to oxygenate his/her system. The laryngoscope utilizes either a lighted straight or curved blade that allows visualization of the vocal cords, indicating the opening of the trachea. This lighted blade is used to keep the tongue from obstructing the medical provider's view of the vocal cords. The tip of the blade lifts the epiglottis, thereby providing a direct view into the patient's trachea, and reducing the risk of intubating the esophagus instead. Laryngoscopes in the past have used halogen or LED bulbs to provide a white light source on the laryngoscope blade to illuminate the vocal cords during laryngoscopy. Even with a light source on the laryngoscope blade, viewing of the vocal cords has still proven difficult during laryngoscopy. Accordingly, without the ability to view the vocal cords, many possible laryngoscopy procedures are not performed successfully, resulting in additional harm or death for the patient.

SUMMARY OF THE INVENTION

To solve these problems and others, an aspect of present invention involves a laryngoscope including an improved light source. The laryngoscope blade carries a black light source that emits a black light during laryngoscopy. The black light enhances visualization of the vocal cords so that visualization of the endotracheal tube passing through the

vocal cords is enhanced. The black light emitted from the laryngoscope enhances colors that are white and/or contain phosphors in the region of the vocal cords, enhancing visualization of the target vocal cords. In another implementation of the laryngoscope, the laryngoscope blade carries a black light source and a white light source. A switch on the laryngoscope enables the health care provider to actuate the black light source, the white light source, or to activate both light sources.

An additional aspect of the invention involves a laryngoscope for use in viewing the vocal cords of a patient in performance of an endotracheal intubation. The laryngoscope includes a handle to be gripped by a medical professional in performing the endotracheal intubation; a blade portion extending from the handle to lift the patient's tongue and mandible for viewing the vocal cords and aid in the insertion of an endotracheal tube; a power source; and a black light source powered by the power source and carried by the blade portion to prompt the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords for viewing the vocal cords and passing of the endotracheal tube there between during endotracheal intubation. Another aspect of the invention involves an endotracheal intubation system for performing an endotracheal intubation including the laryngoscope described immediately above; and an endotracheal tube insertable into the patient's mouth, between the patient's vocal cords into the patient's larynx, and into the patient's trachea for opening the patient's airway.

A further aspect of the invention involves a method of performing an endotracheal intubation including using the laryngoscope described immediately above to lift the patient's tongue and mandible for viewing the vocal cords and aid in the insertion of an endotracheal tube; illuminating the patient's vocal cords with the black light source to prompt the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords for viewing the vocal cords; and simultaneously visualizing the patient's vocal cords with the black light source and sliding the endotracheal tube between the patient's vocal cords and into the patient's larynx and trachea.

A still further aspect of the invention involves a laryngoscope blade for use in viewing the vocal cords of a patient in performance of an endotracheal intubation. The laryngoscope blade includes a laryngoscope blade portion connectable to a laryngoscope handle to lift the patient's tongue and mandible for viewing the vocal cords and aid in the insertion of an endotracheal tube; and a black light source carried by the blade portion to prompt the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords for viewing the vocal cords and passing of the endotracheal tube there between during endotracheal intubation.

According to another embodiment, a laryngoscope for use in viewing the vocal cords of a patient in performance of an endotracheal intubation includes a handle to be gripped by a medical professional in performing the endotracheal intubation, and a blade portion pivotally connected to a first/upper end of the handle and extending from the handle to lift the patient's tongue and mandible for viewing the vocal cords and for aiding in the insertion of an endotracheal tube. The handle is of an ergonomically curved or angled overall shape, and has an inner surface with a series of arcuate finger grip indents. In one embodiment, an outwardly projecting blade stop is formed integrally on the inner surface of the handle adjacent the upper end, and prevents the blade from touching the handle. The handle may be curved continuously

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along all or most of its length in an ergonomic shape for comfortable gripping by the user. Alternatively, the handle may have a first end portion extending from one end up to an angled bend, and a second end portion extending from the bend at an angle to the first portion.

Another aspect of the invention involves a laryngoscope handle of a laryngoscope for use in viewing the vocal cords of a patient in performance of an endotracheal intubation, the laryngoscope including a laryngoscope blade connectable to the handle to lift the patient's tongue and mandible for viewing the vocal cords and aid in the insertion of an endotracheal tube. The laryngoscope handle includes a first end; a second end; an inner surface which faces towards a patient during use; and an outer surface, wherein the inner surface of the handle having a plurality of spaced finger grip indents along at least part of the length of the handle between the first and second ends.

One or more implementations of the aspect of the invention described immediately above includes one or more of the following: the handle is at least one of angled and curved to direct the second end towards the blade, when the blade is connected to the handle; the outer surface of the handle includes a convex surface with a radius of curvature in the range of 3 to 5 inches; the outer surface of the handle includes a thumb engaging section with a thumb location for engaging the laryngoscope handle with one's thumb; the thumb engaging section includes an elongated recessed section; the thumb engaging section includes an indicia to indicate proper orientation of the laryngoscope handle; the thumb location is located near the second end of the laryngoscope handle, and further including a second thumb location near the first end of the laryngoscope handle; the plurality of spaced finger grip indents include four spaced finger grip indents; the four spaced finger grip indents include a first finger grip indent that receives an index finger, a second finger grip indent that receives a middle finger, a third finger grip indent that receives a third finger, and a fourth finger grip indent that receives a little finger; the plurality of spaced finger grip indents include three spaced finger grip indents; the three spaced finger grip indents include a first finger grip indent that receives a middle finger, a second finger grip indent that receives a third finger, and a third finger grip indent that receives a little finger; the laryngoscope blade is connected to the second end of the laryngoscope handle, the laryngoscope blade carrying a black light source to prompt the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords for viewing the vocal cords, providing visible definition of the other structures, and passing of the endotracheal tube there between during endotracheal intubation, the black light source emitting electromagnetic radiation having a wavelength in the range of 300 to 450 nm; the laryngoscope blade includes a proximal portion, a distal portion, and a white light source, and the black light source is located closer to the distal portion and the white light is located closer to the proximal portion; the handle has a bend which separates the handle into a first end portion and a second end portion which is bent at an angle in the range from 40 to 60 degrees relative to the first end portion; and/or the blade is pivotally connectable to the handle and the inner surface of the handle has a blade stop projection extending towards the blade, when the blade is pivotally connected to the handle, which restricts contact between the handle and blade, when the blade is pivoted towards the handle.

A further aspect of the invention involves a laryngoscope handle of a laryngoscope for use in viewing the vocal cords of a patient in performance of an endotracheal intubation,

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the laryngoscope including a laryngoscope blade connectable to the handle to lift the patient's tongue and mandible for viewing the vocal cords and aid in the insertion of an endotracheal tube. The laryngoscope handle includes a first end; a second end; an inner surface which faces towards a patient during use; and an outer surface, wherein the handle is at least one of angled and curved to direct the second end towards the blade, when the blade is connected to the handle.

One or more implementations of the aspect of the invention described immediately above includes one or more of the following: the inner surface of the handle having a plurality of spaced finger grip indents along at least part of the length of the handle between the first and second ends; the outer surface of the handle includes a convex surface with a radius of curvature in the range of 3 to 5 inches; the outer surface of the handle includes a thumb engaging section with a thumb location for engaging the laryngoscope handle with one's thumb; the thumb engaging section includes an elongated recessed section; the thumb engaging section includes an indicia to indicate proper orientation of the laryngoscope handle; the thumb location is located near the second end of the laryngoscope handle, and further including a second thumb location near the first end of the laryngoscope handle; the plurality of spaced finger grip indents include four spaced finger grip indents; the four spaced finger grip indents include a first finger grip indent that receives an index finger, a second finger grip indent that receives a middle finger, a third finger grip indent that receives a third finger, and a fourth finger grip indent that receives a little finger; the plurality of spaced finger grip indents include three spaced finger grip indents; the three spaced finger grip indents include a first finger grip indent that receives a middle finger, a second finger grip indent that receives a third finger, and a third finger grip indent that receives a little finger; the laryngoscope blade is connected to the second end of the laryngoscope handle, the laryngoscope blade carrying a black light source to prompt the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords for viewing the vocal cords, providing visible definition of the other structures, and passing of the endotracheal tube there between during endotracheal intubation, the black light source emitting electromagnetic radiation having a wavelength in the range of 300 to 450 nm; the laryngoscope blade includes a proximal portion, a distal portion, and a white light source, and the black light source is located closer to the distal portion and the white light is located closer to the proximal portion; the handle has a bend which separates the handle into a first end portion and a second end portion which is bent at an angle in the range from 40 to 60 degrees relative to the first end portion; and/or the blade is pivotally connectable to the handle and the inner surface of the handle has a blade stop projection extending towards the blade, when the blade is pivotally connected to the handle, which restricts contact between the handle and blade, when the blade is pivoted towards the handle.

An additional aspect of the invention involves a laryngoscope blade for use in viewing the vocal cords of a patient in performance of an endotracheal intubation. The laryngoscope blade includes a laryngoscope blade portion connectable to a laryngoscope handle to lift the patient's tongue and mandible for viewing the vocal cords and aid in the insertion of an endotracheal tube, the laryngoscope blade portion includes a proximal portion and a distal portion; a white light source carried by the laryngoscope blade portion; a black light source carried by the blade portion to prompt the visible effects of fluorescence and phosphorescence with

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respect to the patient's vocal cords for viewing the vocal cords, providing visible definition of the other structures, and passing of the endotracheal tube there between during endotracheal intubation, the black light source located closer to the distal portion and the white light located to the proximal portion, and the black light source emitting electromagnetic radiation having a wavelength in the range of 300 to 450 nm.

One or more implementations of the aspect of the invention described immediately above includes one or more of the following: the black light source emits electromagnetic radiation having a wavelength in the range of 385 to 395 nm; the white light source is a cool white LED with a mcd rating of 100-10,000 millicandela (mcd); an electrical circuit including the white light source and a 150 ohm resistor associated with the white light source to provide 5 ma at 2.9 volts; an electrical circuit including the black light source and a 13 ohm resistor so that the distal black light source is at 49-50 ma at 3.6 volts; an electrical circuit including a 3.6 volt lithium battery power source; an endotracheal intubation system for performing an endotracheal intubation, including a laryngoscope including the laryngoscope blade described in the aspect of the invention described immediately above; and an endotracheal tube insertable into the patient's mouth, between the patient's vocal cords into the patient's larynx, and into the patient's trachea for opening the patient's airway, the endotracheal tube includes a distal portion and an expandable body near the distal portion, the distal portion includes a dimension, and the expandable body includes a dimension less than the dimension of the distal portion of the expandable body during intubation and a dimension greater than the dimension of the distal portion of the expandable body to secure the endotracheal tube in place in the trachea; the distal portion includes a recessed section that carries the expandable body, and the expandable body is recessed in the recessed section so that the expandable body includes a dimension less than the dimension of the distal portion of the expandable body during intubation and so that the expandable body expands to a dimension outside of the recessed section, greater than the dimension of the distal portion, to secure the endotracheal tube in place in the trachea; the distal portion includes a movable sheath that covers the expandable body during intubation and is movable to uncover the expandable body so that the expandable body is expandable to a dimension greater than the dimension of the distal portion, to secure the endotracheal tube in place in the trachea; the distal portion includes at least one of a fluorescent and phosphorescent material that is at least one of enhanced by and reacts to the black light source to aid in visibility and positioning of the endotracheal during intubation; an endotracheal intubation system for performing an endotracheal intubation, including a laryngoscope including the laryngoscope blade of the aspect of the invention described immediately above; an endotracheal tube insertable into the patient's mouth, between the patient's vocal cords into the patient's larynx, and into the patient's trachea for opening the patient's airway; and a stylet for the endotracheal tube, the stylet including at least one of a fluorescent and phosphorescent material that is at least one of enhanced by and reacts to the black light source to aid in visibility and positioning of at least one of the stylet and the endotracheal tube; and/or an endotracheal intubation system for performing an endotracheal intubation, including a laryngoscope including the laryngoscope blade of the aspect of the invention described immediately above; an endotracheal tube insertable into the patient's mouth, between the patient's vocal cords into the patient's larynx, and into the

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patient's trachea for opening the patient's airway; an endotracheal tube introducer including at least one of a fluorescent and phosphorescent material that is at least one of enhanced by and reacts to the black light source to aid in visibility and positioning of at least one of the endotracheal tube introducer and the endotracheal tube.

A further aspect of the invention involves an introducer including a distal portion, an intermediate portion, and a proximal portion, wherein one or more of the distal portion, the intermediate portion, and the proximal portion including at least one of a fluorescent and phosphorescent material that is at least one of enhanced by and reacts to the black light source to aid in visibility and positioning of the introducer.

One or more implementations of the aspect of the invention described immediately above include one or more of the following: the introducer includes a polyethylene body; the introducer is at least one of an endotracheal tube introducer and an orotracheal intubation introducer; the introducer includes smooth outer ends; and/or the introducer includes a length of 50-70 cm.

A still further aspect of the invention involves an endotracheal intubation tube for performing an endotracheal intubation, the endotracheal intubation tube insertable into the patient's mouth, between the patient's vocal cords into the patient's larynx, and into the patient's trachea for opening the patient's airway. The endotracheal intubation tube includes an endotracheal tube body; a distal portion; and an expandable body near the distal portion, wherein the distal portion includes a dimension, and the expandable body includes a dimension less than the dimension of the distal portion of the expandable body during intubation and a dimension greater than the dimension of the distal portion of the expandable body to secure the endotracheal tube in place in the trachea.

One or more implementations of the aspect of the invention described immediately above includes one or more of the following: the distal portion includes a recessed section that carries the expandable body, and the expandable body is recessed in the recessed section so that the expandable body includes a dimension less than the dimension of the distal portion of the expandable body during intubation and so that the expandable body expands to a dimension outside of the recessed section, greater than the dimension of the distal portion, to secure the endotracheal tube in place in the trachea; the distal portion includes a movable sheath that covers the expandable body during intubation and is movable to uncover the expandable body so that the expandable body is expandable to a dimension greater than the dimension of the distal portion, to secure the endotracheal tube in place in the trachea; and/or a stylet for the endotracheal tube, the stylet including at least one of a fluorescent and phosphorescent material that is at least one of enhanced by and reacts to the black light source to aid in visibility and positioning of at least one of the stylet and the endotracheal tube.

Another aspect of the invention involves an endotracheal tube stylet which comprises an elongate, malleable member and an illuminating material comprising at least one of a fluorescent and phosphorescent material extending along at least part of the malleable member to aid in visibility and positioning of an endotracheal tube.

One or more implementations of the aspect of the invention described immediately above includes one or more of the following: the removable sheath includes a substantially tubular portion that covers the distal portion of the endotracheal tube and protect the expandable body; the removable sheath includes a finger portion engageable by a user's

finger to facilitate removal of the removable sheath from the distal portion of the endotracheal tube; the finger portion includes a finger hole engageable by a user's finger to facilitate removal of the removable sheath from the distal portion of the endotracheal tube; and/or the removable sheath carries a lubricant for lubricating the distal portion and the expandable body of the endotracheal tube.

Another aspect of the invention involves a device for use in the performance of an endotracheal intubation. The device includes a proximate portion of a laryngoscope blade, a distal portion of a laryngoscope blade and a connection section allowing the laryngoscope blade to connect and disconnect from the laryngoscope handle. The laryngoscope blade carries an imaging or viewing device and two different light sources all in equal distance from the distal end of the laryngoscope blade. The two light sources include an ultraviolet light source and a white light source. In this aspect of the invention, the light sources allow for the illumination of ultraviolet light being absorbed and self promotes back light from phosphorous reactions.

Yet another aspect of the invention involves a method of performing direct laryngoscopy. In this method, a laryngoscope blade carrying an imaging or viewing device and two different light sources all in equal distance from the distal end of the laryngoscope blade is connected to a laryngoscope handle forming a laryngoscope. The laryngoscope is then used to lift a patient's tongue and mandible for locating and viewing a foreign object in the patient. In this embodiment, the two light sources used in the laryngoscope prompt a visible illumination effect in the patient's epiglottis and vocal cords, and allow for the detection of the foreign object in the patient. The illumination in this embodiment is a result of the absorption of some or all of the ultraviolet light by tissues in the patient and a self-providing back light from phosphorus reactions. The detection of the foreign object then allows for the prompt removal.

Another aspect of the invention involves the use of a single compartment (e.g. epoxy holding) that contains a white light source and a black/ultraviolet light source in the laryngoscope blade.

An additional aspect of the invention involves a device for use in the performance of an endotracheal intubation. The device includes a laryngoscope blade having a proximate portion and a distal portion with a distal end, the laryngoscope blade connectable to a laryngoscope handle through a connection section; at least two different light sources carried by the laryngoscope blade and in equal distance from the distal end of the laryngoscope blade, the two light sources comprising an ultraviolet light source and a white light source that, in combination, allows for the illumination of ultraviolet light being absorbed and self promotes back light from phosphorous reactions; and an imaging device carried by the laryngoscope blade a distance from the distal end that is substantially equal to the distance between the distal end and the ultraviolet light source and the white light source.

One or more implementations of the aspect of the invention described immediately above includes one or more of the following: further comprising an electrical circuit including a 3.6 volt lithium battery power source in the laryngoscope handle; the connection section is configured to cause the light sources to be automatically activated when the laryngoscope blade is connected to the laryngoscope handle; the connection section is configured to cause the imaging device to be automatically activated when the laryngoscope blade is connected to the laryngoscope handle; the imaging device is a camera head; the ultraviolet light source emits

electromagnetic radiation having a wavelength in the range of 300 to 450 nm; the white light is a 2-8 mm LED diode; the white light is a cool white LED with a rating of 100-10,000 millicandela (mcd); the ultraviolet light is an ultraviolet diode; the light sources are in a single epoxy holding; and/or the device is used in a method of performing direct laryngoscopy including connecting the laryngoscope blade and the laryngoscope handle to create a laryngoscope; using the laryngoscope to lift a patient's tongue and mandible for locating and/or viewing a foreign object in the patient; providing the two light sources to: prompt a visible illumination effect in the patient's epiglottis and vocal cords resulting from: the absorption of some or all of the ultraviolet light by tissues in the patient; and a self-providing back light from phosphorus reactions; and allow a reaction with a foreign body in the patient; and locating the foreign object in the patient.

A further aspect of the invention involves a laryngoscope for use in viewing the vocal chords and trachea of a patient while performing endotracheal intubation or attempting to remove a foreign body obstructing the trachea. The laryngoscope includes a laryngoscope handle adapted for gripping by a user; a laryngoscope blade having a proximal portion configured for connection to the laryngoscope handle and a distal portion configured for insertion into a patient's mouth into an operative position, the distal portion having a distal end facing the opening of the trachea in the operative position; at least two different light sources carried by the laryngoscope blade and both located at a first distance from the distal end of the laryngoscope blade, the at least two light sources comprising an ultraviolet (UV) light source and a white light source, the light sources together configured to provide illumination in a portion of the trachea extending from the trachea opening, and the UV light source configured to prompt the visible effects of fluorescence and phosphorescence in illuminated tissues in the trachea and to produce phosphorescence from absorption of UV light in a foreign body having a phosphor content located in the illuminated portion of the trachea; and an imaging device carried by the laryngoscope blade and configured to produce an image of the illuminated portion of the trachea and any foreign object obstructing the illuminated portion.

One or more implementations of the aspect of the invention described immediately above includes one or more of the following: the imaging device is at substantially the same distance from distal end as the light sources; the light sources and imaging device are in a single unit mounted in distal portion of the blade; the device is used in a method of retrieving a foreign object from a patient's trachea including illuminating both of the light sources of the laryngoscope; inserting the distal portion of the laryngoscope into a patient's mouth over a patient's tongue and mandible and into the throat area to an operative position in which a portion of the trachea extending from the vocal cords is illuminated by the light sources and the UV light source prompts the visible effects of fluorescence and phosphorescence in the tissue of the illuminated portion of the trachea and UV light is absorbed by any phosphor content in a foreign object trapped in the illuminated portion of trachea to produce phosphorescence to further illuminate the object; inserting the ends of forceps into the trachea and advancing the ends of the forceps towards the illuminated object while viewing the illuminated object to aid in locating the object with the forceps; and retrieving the object from the trachea using the forceps; the method further comprises viewing the object on an imaging device connected to the camera; the method further comprises viewing the object as deep as one

circoid ring into the trachea; the method further comprises viewing the object as deep as two circoid rings into the trachea; the method further comprises viewing the object as deep as three circoid rings into the trachea; and/or the method further comprises viewing the object as deep as four circoid rings into the trachea.

Further objects and advantages will be apparent to those skilled in the art after a review of the drawings and the detailed description of the preferred embodiments set forth below.

BRIEF DESCRIPTION OF THE DRAWINGS

FIG. 1 is a schematic depiction of a laryngoscope being used to view a patient's larynx;

FIG. 2 is a perspective view of a laryngoscope in accordance with an embodiment of the present invention;

FIG. 3A is a bottom plan view of the laryngoscope of FIG. 2, and illustrates an embodiment of a switch that may be used with the laryngoscope of FIG. 2;

FIG. 3B is a bottom plan view of an alternative embodiment of a laryngoscope, and illustrates an embodiment of a black light source on the bottom of the laryngoscope;

FIG. 4 is an embodiment of an endotracheal tube that may be used with the laryngoscope of FIGS. 1-3.

FIG. 5 is an embodiment of a kit of endotracheal tubes that may be used with the laryngoscope of FIGS. 1-3.

FIG. 6 is an alternative embodiment of an endotracheal tube that may be used with the laryngoscope of FIGS. 1-3 or a standard laryngoscope.

FIG. 7 is an embodiment of a pair of protection intubation glasses that may be used with the laryngoscope of FIGS. 1-3 and/or the endotracheal tube(s) of FIGS. 4-6.

FIG. 8 is a side-elevational view of a separate laryngoscope blade in accordance with an embodiment of the present invention;

FIG. 9 is a side-elevational view of a separate laryngoscope blade in accordance with another embodiment of the present invention;

FIG. 10 is a side-elevational view of an embodiment of a pair of forceps;

FIG. 11 is a rear perspective view of an alternative embodiment of a laryngoscope with an ergonomically shaped handle;

FIG. 12 is a side elevation view of the laryngoscope of FIG. 11;

FIG. 13 is a front perspective view of the laryngoscope of FIGS. 11 and 12;

FIG. 14 is a cross-sectional view of the laryngoscope on the lines 14-14 of FIG. 11;

FIG. 15 is a rear perspective view of another embodiment of a laryngoscope with a shaped handle; and

FIG. 16 is a side elevation view of the laryngoscope of FIG. 15.

FIG. 17 is a perspective view of another embodiment of a laryngoscope.

FIG. 18 is a bottom plan view of the laryngoscope illustrated in FIG. 17.

FIG. 19 is a front elevational view of the laryngoscope illustrated in FIG. 17.

FIG. 20 is a right side elevational view of the laryngoscope illustrated in FIG. 17.

FIG. 21 is a left elevational view of the laryngoscope illustrated in FIG. 17.

FIG. 22 is a rear elevational view of the laryngoscope illustrated in FIG. 17.

FIG. 23 is a top plan view of the laryngoscope illustrated in FIG. 17.

FIG. 24 is a front elevational view of another embodiment of a laryngoscope.

FIG. 25 is a cross-sectional view of the handle of the laryngoscope illustrated in FIG. 24.

FIG. 26 is an exemplary graph of Radiant Power versus Forward Current for the black light source of the laryngoscope shown in FIG. 24.

FIG. 27 is an exemplary graph of Radiant Power versus Wave Length for the black light source of the laryngoscope shown in FIG. 24.

FIG. 28 is an exemplary graph of Peak Wave Length versus Forward Current for the black light source of the laryngoscope shown in FIG. 24.

FIG. 29 is an exemplary graph of Radiant Power versus Time for the black light source of the laryngoscope shown in FIG. 24.

FIG. 30 is an embodiment of an introducer (e.g., endotracheal tube introducer) that may be used with a black light source such as the black light source of the laryngoscopes described and shown herein.

FIG. 31 is an embodiment of a stylet (e.g., endotracheal tube stylet) that may be used with a black light source such as the black light source of the laryngoscopes described and shown herein.

FIGS. 32A and 32B are side elevational/end views of a stylet body of the stylet shown in FIG. 31.

FIGS. 33A, 33B, 33C are top perspective, bottom perspective, and cross-sectional views of the plug connector of the stylet shown in FIG. 31.

FIG. 34 is a further embodiment of a stylet (e.g., endotracheal tube stylet) that may be used with a black light source such as the black light source of the laryngoscopes described and shown herein.

FIGS. 35A and 35B are side elevational/end views of a stylet body of the stylet shown in FIG. 34.

FIGS. 36A, 36B, 36C are top perspective, bottom perspective, and cross-sectional views of the plug connector of the stylet shown in FIG. 31.

FIG. 37A is a partial perspective view of another embodiment of an endotracheal tube with a balloon and movable cuff sheath and shows the distal portion of the endotracheal tube with the movable cuff sheath in an extended position where it covers the balloon.

FIG. 37B is a partial perspective view of the endotracheal tube of FIG. 37A and shows the distal portion of the endotracheal tube with the movable cuff sheath in a retracted position where the balloon is not covered and is in an expanded configuration.

FIG. 38A is a partial front elevational view of a further embodiment of an endotracheal tube with a balloon shown in a collapsed, low-profile position.

FIG. 38B is a partial front elevational view of the endotracheal tube of FIG. 38A and shows the balloon in an expanded configuration.

FIGS. 39A, 39B, 39C, 39D, 39E, 39F, 39G are perspective, left side elevational, right side elevational, rear elevational, front elevational, top plan, and bottom plan views of another embodiment of a laryngoscope handle.

FIGS. 40A, 40B, 40C, 40D, 40E, and 40F are front elevational, top plan, rear elevational, bottom plan, right side elevational, and left side elevational views of another embodiment of a laryngoscope blade.

FIGS. 41A, 41B, 41C, 41D, 41E, and 41F are right side elevational, rear elevational, left side elevational, front

elevational, bottom plan, and top plan views of an additional embodiment of a laryngoscope blade.

FIGS. 42A, 42B, 42C, 42D, 42E, 42F, and 42G are right side elevational, rear elevational, left side elevational, front elevational, bottom plan, perspective, and top plan views of a further embodiment of a laryngoscope blade.

FIGS. 43A, 43B, 43C, 43D, 43E, and 43F are right side elevational, rear elevational, left side elevational, front elevational, bottom plan, and top plan views of a still further embodiment of a laryngoscope blade.

FIGS. 44A, 44B, 44C, 44D, 44E, 44F, and 44G are right side elevational, rear elevational, left side elevational, perspective, front elevational, bottom plan, and top plan views of an additional embodiment of a laryngoscope blade.

FIGS. 45A, 45B, 45C, 45D, 45E, 45F, and 45G are right side elevational, rear elevational, left side elevational, perspective, front elevational, bottom plan, and top plan views of another embodiment of a laryngoscope blade.

FIGS. 46A, 46B, 46C, 46D, 46E, and 46F are right side elevational, rear elevational, left side elevational, front elevational, bottom plan, and top plan views of a further embodiment of a laryngoscope blade.

FIGS. 47A, 47B, 47C, 47D, 47E, and 47F are right side elevational, rear elevational, left side elevational, front elevational, bottom plan, and top plan views of a further embodiment of a laryngoscope blade.

FIGS. 48A, 48B, 48C, 48D, 48E, and 48F are right side elevational, rear elevational, left side elevational, front elevational, bottom plan, and top plan views of a still further embodiment of a laryngoscope blade.

FIGS. 49A, 49B, 49C, 49D, 49E, 49F, and 49G are right side elevational, rear elevational, left side elevational, perspective, front elevational, bottom plan, and top plan views of a yet further embodiment of a laryngoscope blade.

FIGS. 50A, 50B, and 50C are side-elevational views of an embodiment of a removable sheath for a cuff of an endotracheal tube.

FIGS. 51 and 52 are an exploded perspective view and a perspective view of another embodiment of a laryngoscope blade that includes a video camera next to an ultraviolet light and a white light.

FIG. 53 is a schematic depiction of the laryngoscope in FIGS. 51 and 52 being used to remove an obstruction from a patient.

FIG. 54 illustrates an embodiment of a combination ultraviolet/black light source and white light source.

DETAILED DESCRIPTION OF PREFERRED EMBODIMENTS

With reference to FIGS. 1 and 2, a laryngoscope 100 constructed in accordance with an embodiment of the invention will be described. In FIG. 1, the laryngoscope 100 is shown placed in the mouth of a patient 112 for viewing the vocal cords adjacent the larynx and to aid in the insertion of an endotracheal tube 200 (FIG. 4) past the vocal cords. The laryngoscope 100 includes a handle or handgrip 114 and a blade portion 116, the latter being used to lift the tongue and mandible 118 out of the way for viewing the vocal cords.

As shown in FIG. 2, the blade portion 116 is pivotally connected to a handle cap 120. The blade portion 116, the handle cap 120, and the handle 114 can be readily assembled together for use. In the embodiment shown, when assembled, a white light source 150 and a black light source 160 are automatically actuated. In an alternative embodiment, the blade portion 116 is directly connected to a top of the handle 114 (i.e., there is no handle cap). The handle 114

is essentially a hollow tube having a closed lower or outer end 122 (FIG. 3) and an open upper end. The handle cap 120 is removably secured to an open upper end of the handle 114. A power source 123 (e.g., one or more dry cell batteries) is located within the handle cavity to provide power for light source(s) to be described.

A side of the handle 114 includes a switch 128 in the form of two pressure/push buttons 129, 130 interconnected with the power source 123, the white light source 150, and the black light source 160 that, when pressed (e.g., by a user's thumb), deactivate the respective light sources 150, 160. When the laryngoscope 100 is clicked together/assembled, both light sources 150, 160 are placed in electrical communication with the power source 123 and are automatically turned on. In the embodiment shown, push button ("white light button") 129 controls the white light source 150 so that pushing on the white light button 129 turns off the white light source 150 and push button ("black light button") 130 controls the black light source 160 so that pushing on the black light button 130 turns off the black light source 160. Thus, by applying pressure to the push buttons 129, 130, the respective light sources 150, 160 are turned off. Removing the pressure to the push buttons 129, 130 causes the respective light sources 150, 160 to be turned back on. Accordingly, the switch 128 enables the laryngoscope 100 to be switched between at least a "both on" condition where both black light is emitted from the black light source 160 and white light is emitted from the white light source 150, a black light condition where black light is emitted from the black light source 160 and the white light source 150 is off, and a white light condition where white light is emitted from the white light source 150 and the black light source 160 is off.

With reference to FIG. 3, an alternative embodiment of a switch 131 located on a bottom 124 of the handle 114 is shown. The switch 131 cooperates with electronics in the laryngoscope 100 for switching between an "off" condition, a black light condition, a white light condition, and a "both on" condition. In the embodiment shown, the switch 131 is a rotating switch with a rotating knob 132 that rotates between different positions to actuate the above conditions.

In alternative embodiments, other types of switches may be used (e.g., push-button switch, a toggle switch) on the bottom 124 of the handle 114 (or at other locations on the laryngoscope 100) to switch between an "off" condition and one or more of a black light condition, a white light condition, and a "both on" condition. In alternative embodiments, the switch 128, 131 may switch between conditions in addition to or other than an "off" condition, a black light condition, a white light condition, and a "both on" condition. For example, in an alternative embodiment, where the laryngoscope 100 includes only a black light source 160, the switch 128, 131 may switch the laryngoscope 100 between an "off" condition and a black light condition.

One or more light sources 140 are interconnected with the power source 123 in the handle 114. In the embodiment shown, as discussed above, the one or more light sources 140 include two light sources: 1) a white light source 150, and 2) a black light source 160. Example white light sources 150 include, but not by way of limitation, a white halogen light, a white incandescent light, and a white LED. The black light source 160 emits long wave UVA radiation and very little visible light. The black light source is a lamp emitting electromagnetic radiation that is almost exclusively in the soft near ultraviolet range. The black light source 160 prompts the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords and the

glottis, which is the space between the vocal cords, during laryngoscopy. The black light source **160** may be a Wood's light made using Wood's glass, which is a nickel-oxide-doped glass, which blocks substantially all visible light above 400 nanometers. In alternative embodiments, other black light sources **160** (e.g., LED(s)) may be used. In one embodiment, the black light source **160** emits electromagnetic radiation including a wavelength in the range of 315 to 400 nm, without emitting substantial electromagnetic radiation including a wavelength outside of the range of 315 to 400 nm. In another embodiment, the black light source **160** includes a wavelength of 385-395 nm.

In the embodiment shown, the blade portion **116** is a curved Macintosh blade; however, in alternative embodiments, other types of blades (e.g., straight Miller/Robertshaw blade) may be used. The blade portion **116** carries the one or more light sources **140**. Although the one or more light sources **140** are shown on a top of the blade portion **116**, in alternative embodiments, the one or more light sources **140** are disposed at one or more of the following locations: a side of the blade portion **116**, a bottom of the blade portion **116**, a top of the blade portion **116**, a distal tip of the blade portion **116**, and other locations on or relative to the blade portion **116**.

With reference to FIG. 3B, in a further embodiment, in addition to or instead of the one or more light sources **140** being carried by the blade portion **116**, a black light source (e.g., black light source **160**) is carried by the bottom **124** of the handle **114** for emitting black light from the bottom **124** of the handle **114**. In such an embodiment, a switch (e.g., switch **128**) for controlling the black light source on the bottom **124** of the handle **114** is preferably located in a location other than the bottom **124** of the handle **114**.

With reference to FIG. 4, an embodiment of an endotracheal tube **200** that may be used with the laryngoscope **100** (as part of an endotracheal intubation system) in performing endotracheal intubation will be described. The endotracheal tube **200** includes a clear plastic intubation tube **210** with an elongated central lumen. The intubation tube **210** includes a larger-diameter open upper end **212**, which may include a cap, and a pointed open lower end or tip **214**. An elongated scope (e.g., a fiberoptic scope) **220** may be received within the lumen of the intubation tube **210**. The scope **220** includes a distal viewing tip **230**. A plastic transparent holding sheath may cover the scope **220**. A longitudinally built-in narrow malleable metal intubation stylet **240**, which is a narrow piece of flat metal, may be built into the holding sheath and adhered to an outer wall of the holding sheath for controlling the geometry/shape of the scope **220**/endotracheal tube **200** to match the physiology/anatomy of the patient during endotracheal intubation.

In an alternative embodiment, one or more of the intubation tube **210** and the stylet **240** include a fluorescent color or other color/substance that is enhanced by the black light or that reacts to the black light (on the entire tube **210**/stylet **240** or a portion and/or component thereof).

For example, but not by way of limitation, in one or more embodiments, the intubation tube **200** includes a fluorescent striping on the body of the ET tube **210**, fluorescent coloring of the balloon/cuff shown near the distal end of the tube **200**, and/or on the BVM connector near proximal end of tube **200** causes device to naturally phosphoresce under black light, clearly identifying ET tube tracking through the vocal cords into the trachea.

A method of performing endotracheal intubation using the laryngoscope **100** and the endotracheal tube **200** will be described. The black light source **160** of the laryngoscope

100 is activated (e.g., when the laryngoscope **100** is clicked together/assembled). The blade portion **160** of the laryngoscope **100** is inserted into the patient's mouth and behind the patient's tongue and mandible **118**. By gripping the handle **114** with one's hand, the tongue and mandible **118** are lifted for viewing the vocal cords adjacent the larynx and to aid in the insertion of the endotracheal tube **200** past the vocal cords. The black light emitted from the laryngoscope **100** prompts the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords and the glottis, making the patient's vocal cords and the glottis visible either directly by the eyes of the medical provider or via the scope **220** of the endotracheal tube **200**. The endotracheal tube **200** is inserted into the patient's mouth, between the patient's visible vocal cords into the larynx, and then into the trachea of the patient in a usual manner. The stylet **200** of the endotracheal tube **200** may be used to shape the scope **220**/endotracheal tube **200** to the individual anatomy/pathology of the patient.

As discussed above, in the embodiment of the laryngoscope **100** shown in FIG. 1, applying pressure to the push buttons **129**, **130** causes the respective light sources **150**, **160** to be deactivated and removing the pressure to the push buttons **129**, **130** causes the respective light sources **150**, **160** to be re-activated. The medical provider operates the push buttons **129**, **130** of the switch **128** (e.g., to cause only black light to be emitted, only white light to be emitted, or both types of light to be emitted) so that optimal viewing of the vocal cords occurs. The medical provider may prefer to use the black light condition and/or the white light condition, depending on external lighting conditions, the individual anatomy/pathology of the patient, the patient's condition, and other factors.

With reference to FIG. 5, in another embodiment of the above endotracheal tube **200**, a kit **300** of endotracheal tubes **200**, intubation tubes **210**, and/or stylets **240** of different sizes (e.g., different weight, height, and/or depth; adult version, pediatric version) are color-coded with different fluorescent colors or other color/substance that is enhanced by the black light or that reacts to the black light. For example, but not by way of limitation, the intubation tube **210** of each different endotracheal tube **200** is coated with a unique fluorescent colored material or other color/substance that is enhanced by the black light or that reacts to the black light. The entire endotracheal tube **200** may include a fluorescent color or one or more portions of the endotracheal tube **200** may include one or more fluorescent colors (or other color/substance that is enhanced by the black light or that reacts to the black light). For example, but not by way of limitation, a cap of the endotracheal tube **200** may include a unique fluorescent color (or other color/substance), the intubation tube **210** may include a unique fluorescent color (or other color/substance), and/or the stylet **240** may include a unique illuminating material or substance, such as a fluorescent color (or other color/substance) for identifying the proper size endotracheal tube **200**, intubation tube **210**, and/or stylet **240**, and for improving visualization of the endotracheal tube **200**, intubation tube **210**, and/or stylet **240** during endotracheal intubation. Using the black light source **160** of the laryngoscope **100**, one may easily identify the correct-sized endotracheal tube **200**, intubation tube **210**, and/or stylet **240** by shining black light on the kit of endotracheal tubes **200**, intubation tubes **210**, and/or stylets **240** identified by different fluorescent colors (or other color/substance) so that the proper-sized endotracheal tube **200**, intubation tube **210**, and/or stylet **240** for the patient/application is selected. The different-size/fluorescent-color endo-

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tracheal tubes **200**, intubation tubes **210**, and/or stylets **240** are easy to identify with a black light source, especially in no-light, low-light, or dark conditions. Further, the fluorescent (or other color/substance) endotracheal tube **200**, intubation tube **210**, and/or stylet **240**, in combination with the black light laryngoscope **100**, improves visualization of the endotracheal tube **200**, intubation tube **210**, and/or stylet **240** passing the vocal cords during endotracheal intubation.

With reference to FIG. 6, in another embodiment, the stylet **240** and/or the endotracheal tube **200** includes a black light source **350** that emits black light to enhance visualization of the vocal cords during endotracheal intubation. For example, the stylet **240** and/or the endotracheal tube **200** with black light source **250** may be used in conjunction with the laryngoscope **100** discussed above with respect to FIGS. 1-3, or in conjunction with a normal laryngoscope that does not have a black light source **150**.

With reference to FIG. 7, an embodiment of a pair of protection intubation glasses **400** includes lenses **410** configured (e.g., tinted to a particular shade) so that when used in conjunction with the black light sources described above during endotracheal intubation, the visibility of the vocal cords is intensified/enhanced.

With reference to FIG. 8, an embodiment of a separate laryngoscope blade **500** that may be detachably connected to a separate laryngoscope handle (e.g., handle **114**) will be described. In the embodiment shown, the blade **500** is a curved Macintosh blade; however, in alternative embodiments, other types of blades (e.g., straight Miller/Robertshaw blade) may be used.

The blade **500** may be made of stainless steel, plastic, or a combination of stainless steel and plastic. In other embodiments, other materials are used.

The blade **500** includes a blade portion **516** with a distal portion **530** and a proximal portion **540**. The blade portion **516** carries a white light source **150** and a black light source **160**. The black light source **160** is located distally of (i.e., closer to the distal portion **530** relative to) the white light source **150** on the blade portion **516**. The advantage of locating the black light source **160** distally of the white light source **150** is that, in use, the proximal white light source **150** provides general illumination (e.g., of the interior of the mouth and back of the patient's throat) while the distal black light source **160**, which is disposed closer to the patient's vocal cords and the glottis, provides directed black light illumination of the patient's vocal cords and the glottis, prompting the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords and the glottis. In another embodiment (FIGS. 17-23), the distal black light source **160** is disposed 1.5 to 2.0 inches in front of proximal white light source **150**. In alternative embodiments, the white light source **150** and/or the black light source **160** are located at other positions/locations/relative distances than those shown.

The blade **500** includes a connection section **550** for mechanically coupling the blade **500** to a top of the separate laryngoscope handle and electrically coupling the white light source **150** and the black light source **160** to a power source in the laryngoscope handle. Alternatively, the blade **500** carries its own power source for powering the white light source **150** and the black light source **160**. When the blade **500** is connected to the laryngoscope handle, the connection section **550** is configured so that both the white light source **150** and the black light source **160** are automatically activated and when the blade **500** is disconnected to the laryngoscope handle, the white light source **150** and the black light source **160** are automatically deactivated.

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This automatic activation/deactivation may be achieved by electrical connectors and/or switch(es) (e.g., an electrically conductive ball contact on connection portion of handle and a cooperating electrically conductive ball contact on connection portion of blade **500** that contact each other to close the circuit when the blade **500** and the handle are connected and lose contact with each other to open the circuit when the blade **500** and the handle of disconnected). For example, the mechanical connection between the connection section **550** and the laryngoscope handle may put the power source in the handle in electrical communication with the white light source **150** and the black light source **160** or may cause a switch at the interface of the connection section **550** and the laryngoscope handle to be closed. In an alternative embodiment, the blade **500** and/or laryngoscope handle carries a user controllable switch to control activation/deactivation of the white light source **150** and the black light source **160** (e.g., both on, both off, one on and one off).

FIG. 9 illustrates another embodiment of a separate laryngoscope blade **600** that is the same as the blade **500**, except the blade **600** includes only a black light source **160** instead of both a white light source **150** and a black light source **160**.

With reference to FIG. 10, an embodiment of a pair of stainless steel disposable forceps **700** including distal portions **710** of jaws **720** coated with (e.g., dipped in) a fluorescent colored material/substance (or other color/substance) that is enhanced by the black light or that reacts to the black light is shown. In an alternative embodiment, the forceps **700** are made of a plastic material including the fluorescent colored material/substance (or other color/substance) that is enhanced by the black light or that reacts to the black light. The forceps **700** include a handle **730** at a proximal end and the distal jaws **720** at an opposite end for gripping an object. The forceps **700** pivot about a pivot section **740**. In use, the forceps **700** are used to grip an object (e.g., to remove an object from the patient's body). Black light (e.g., from any of the black light devices described above and shown herein) is directed at the object and the jaws **720** of the forceps **700**. The fluorescent colored material/substance is enhanced by the black light, allowing the user to see exactly where to grab the object and, most importantly, not cause damage to surrounding tissue. The user then grabs the object with the jaws **720** of the forceps **700** and, if appropriate, removes the object from the patient's body. Although the forceps **700** in the embodiment shown are Magill-type forceps, in alternative embodiments, other types of forceps with jaws **720** coated with a fluorescent material/substance may be used.

FIGS. 11 to 14 illustrate another embodiment of a laryngoscope **800** having an ergonomically shaped handle **802** and a blade **804** pivotally connected to a first/upper end of the handle via pivot pin **805**. In one embodiment, a connection portion **820** of the blade pivots into latching engagement with a suitable conventional latching or click-lock mechanism (not illustrated) at the top of the handle when in the operative position shown in the drawings. In the embodiment shown, the blade is a curved Macintosh blade; however, in alternative embodiments, other types of blades (e.g., straight Miller/Robertshaw blade) may be used. The blade **804** carries one or more light sources (not illustrated) as illustrated and described above in connection with the embodiments of FIGS. 1 to 10, such as light sources **140** on a top surface of the blade as illustrated in FIG. 2. As described in connection with the previous embodiments, the one or more light sources may be a white light source, a black light source, or a black light source and a white light

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source. The one or more light sources may alternatively be disposed at one or more of the following locations: a side of the blade, a bottom of the blade, a top of the blade, a distal tip of the blade, and other locations on or relative to the blade. The light sources may be any of the alternative types of light sources as described above in connection with the preceding embodiments.

In this embodiment, handle **802** is of a continuously curved, ergonomic shape with a series of four finger grip indents **806** on its inner, concave surface. A projecting blade stop **808** is also located on the inner surface adjacent the first/upper end of the handle. The blade stop **808** may be formed in a first/upper end cap **810** which incorporates the blade pivot mount, as illustrated in FIG. **14**. In an alternative embodiment, the blade **804** is directly connected to the first/upper end of the handle **802**, eliminating the separate end cap **810** and replacing it with an integrally formed first/upper end portion of the handle **802** of similar shape to end cap **810**, including blade stop **808**. The handle **802** may be made of any suitable rigid and lightweight material such as metal or plastic.

The first/upper end cap **810** or end portion of the handle **802** is pivotally assembled with the blade **804** in a similar or identical manner to the previous embodiments, and a second/lower end cap **812** is threadably engaged with a lower second/open end of the handle for access to a battery cavity containing a power source **814** (e.g. one or more dry cell batteries such as a lithium battery, single 3.6 volt lithium battery powering a white light source and a black light source carried by the blade **804** in a manner similar to that shown in FIG. **8**) which supplies power to the light source or sources, as best illustrated in FIG. **14**. As illustrated in FIG. **14**, the battery is connected to contact pin **815** in end cap **810** via spring loaded connector wire **816**. Contact pin **814** projects into a contact recess **818** in the pivotally mounted portion **820** of the blade. Although not shown in the drawings, it will be understood that the contact in recess **818** is suitably connected to a light source or sources (not illustrated) mounted on the blade **804** in a conventional manner, so that the light source or sources are automatically placed in communication with the power source when the blade **804** is assembled or clicked together with the upper part of the handle **802** in the operative condition of FIGS. **11** to **14**, and are automatically turned off when the blade is released or disassembled from the upper part of the handle for storage when not in use, for example when the blade is released from the conventional click lock or latching mechanism (not illustrated) at the first/upper end of the handle and pivoted down towards the handle. The blade stop **808** prevents the blade **804** from contacting the handle when pivoted.

As in the previous embodiments, in alternative embodiments of the laryngoscope **800**, other types of switches may be used (e.g., push-button switch, a toggle switch) on the bottom of the handle (or at other locations on the laryngoscope **800**) to switch between an "off" condition and one or more of a black light condition, a white light condition, and a "both on" condition. In alternative embodiments, the switch may switch between conditions in addition to or other than an "off" condition, a black light condition, a white light condition, and a "both on" condition.

The continuously curved handle along with the finger grips **806** which are gripped by the health care provider during intubation provides an ergonomic design which is easier and more comfortable to use and which is angled more efficiently for proper actuation. As illustrated in FIGS. **11** and **12**, the outer, convex surface of the handle is

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smoothly curved apart from an elongate recessed region **822** in which an arrow sign **824** pointing to the second/lower end of the handle is provided. The arrow **824** provides an indication of the direction of use or manipulation of the handle in order to perform the procedure. The finger grips help the health care provider to hold the device securely and reduce the risk of the handle slipping out of the health care provider's hand.

The handle curvature may be a continuous curve of constant radius of curvature, or may be of varying curvature along at least part of its length. Due to the handle curvature, when the blade **804** is inserted into a patient's mouth as in FIG. **1**, the second/lower end portion of the handle **802** bends down rather than upwardly as is the case with straight handle **114** of FIG. **1**, making it easier and more efficient for the health care provider to manipulate and position the blade **804** while viewing the patient's trachea during the procedure. The radius of curvature of the outside surface of the handles (FIGS. **11-14**, **17-23**, and **39**) is 4.1 inches. In a preferred embodiment, the radius of curvature of the outside surface of the laryngoscope handle is in the range from 3 to 5 inches. The second/lower end portion of the handle may be bent or curved through an angle of around 40 to 60 degrees relative to the first/upper end of the handle which is attached to the blade.

FIGS. **15** and **16** illustrate a modified laryngoscope **900** in which the handle **902** has an angled bend **904** at approximately the mid-point in its length, separating it into an upper, straight portion **905** and a lower straight portion **906** which is bent at an angle to the first/upper end portion. The angle between the upper portion **905** and lower portion **906** may be of the order of 40 to 60 degrees, for example 45 degrees. Apart from the handle being bent at an angle rather than continuously curved as in the embodiment of FIGS. **11** to **14**, other parts of the laryngoscope of FIGS. **15** and **16** are identical to those of the previous embodiment, and like reference numerals are used for like parts as appropriate. As in the previous embodiment, the handle **902** has finger grip indents **806** and a blade stop **808** on its inner surface, facing the blade **804**. The finger grip indents **822** allow the health care provider to grip the handle **902** more comfortably and securely, while the angled end portion allows the health care provider to position the blade **804** more efficiently during the procedure.

FIGS. **17-23** illustrate another embodiment of a laryngoscope **1000** that is generally similar to the laryngoscope **800** discussion above with respect to FIGS. **11-14**, which is incorporated herein, but includes a distal black light source that is disposed 1.5 to 2.0 inches in front of a proximal white light source. In alternative embodiments, the distance between the distal black light source and the white light source is a distance other than 1.5 to 2.0 inches. Portions of the distal black light source and the proximal white light source are disposed through lateral holes in a curved vertical wall of laryngoscope blade (e.g., distal/bulb ends of black light source and white light source are disposed on one side of vertical wall and proximal ends of black light source and white light source are disposed on an opposite side of vertical wall). The laryngoscope **1000**, and handle **1005**, in particular, increases the effectiveness of blade insertion and placement through an improved ergonomic design. The laryngoscope **1000** and handle **1005** improve entry angle and handle control (to allow more effective tongue sweep and mandible lift). The laryngoscope **1000** and handle **1005** enable instinctive lift-direction to help avoid oral cavity damage. The laryngoscope **1000** limits "fulcruming" of blade/handle unit, which often leads to dental damage. In the

past, the laryngoscopes used handle devices consisting of straight “flashlight-like” tubes that were non-ergonomic, difficult to control, and may promote use that can injure structures in the oral cavity.

The laryngoscope handle **1005** in FIGS. **17-23** is a four-finger-grip-indented handle **1005** made of machined aluminum and includes an ergonomic “pistol-grip” design that provides a proper angle for mandible lift and tongue sweep used in laryngoscopy, and provides ergonomical shape and design to prevent fulcruming and breaking teeth.

In the four-finger-grip-indented handle **1005** shown and described with respect to FIGS. **17-23**, the laryngoscope is oriented in an opposite manner than that shown in FIG. **22** (i.e., second/lower end **1002** of handle **1005** oriented up and blade **1004** oriented down). A user grips handle **1005** by holding the handle **1005** in the palm of one’s hand and presses one’s thumb against the arrow **824** (FIGS. **19, 21, 22**) in a first thumb location **1010**, with the arrow **824** facing up (second/lower end **1002** oriented up) for proper orientation of the handle **100** during normal laryngoscopic use as shown in FIG. **1**. The first thumb location **1010** is located in the elongate recessed region **822**, near the first/upper end of handle **1005**. In this position, the user’s thumb is collinear with and longitudinally aligned with the elongated recessed region **822** and the handle **1005**. The handle **1000** includes a second thumb location **1030** near a first/upper end **1032** of the laryngoscope handle **1005** that is engaged by the user’s thumb during pediatric laryngoscopy. In this position, the user’s thumb is substantially perpendicular with the handle **1005**, giving the user a more delicate hold on the handle **1000** to help ensure that the child/toddler/baby is not injured during the pediatric laryngoscopy procedure.

In the laryngoscope orientation described above, the user wraps four fingers around and in four finger grip indents **1032, 1034, 1036, 1038**. The user’s index finger wraps around and in a first finger grip indent **1032** closest to second/lower end **1002** of handle **1005**, the user’s middle finger wraps around and in a second finger grip indent **1034** next closest to second/lower end **1002** of handle **1005**, the third finger wraps around and in a third finger grip indent **1036** next closest to second/lower end **1002** of handle **1005**, and the little finger wraps around and in a finger grip indent **1038** closest to first/upper end **1032** of handle **1005** (closest to where blade **1040** connects to the handle **1005**). This design is an ergonomic design that provides a proper angle for mandible lift and tongue sweep used in adult laryngoscopy, and helps to ensure the right amount of torque/leverage in adult laryngoscopy to prevent fulcruming and breaking teeth.

With reference to laryngoscope handle **1045** shown in FIGS. **39A-39G**, the description of the handles shown and described with respect to FIGS. **11-14** and **17-23** is incorporated herein. The laryngoscope handle **1045** is made of machined aluminum and includes an ergonomic “pistol-grip” design that provides a proper angle for mandible lift and tongue sweep used in pediatric laryngoscopy, and provides ergonomical shape and design to prevent fulcruming and breaking teeth. Although the laryngoscope handle **1045** shown in FIGS. **39A-39G** is designed for pediatric laryngoscopy use, in alternative embodiments, the laryngoscope handle **1045** may be used for adult laryngoscopy. A main difference between the laryngoscope handle **1045** shown in FIGS. **39A-39G** and the handles shown and described with respect to FIGS. **11-14** and **17-23** is that the laryngoscope handle **1045** shown in FIGS. **39A-39G** includes a series of three finger grip indents on its inner, concave surface instead

of a series of four finger grip indents **806** on its inner, concave surface (FIGS. **11-14** and **17-23**).

In the three-finger-grip-indented handle **1045** shown with respect to FIGS. **39A-39G**, the laryngoscope/handle **1045** is oriented in an opposite manner than that shown in FIG. **39A** (i.e., second/lower end **1047** of handle **1045** oriented up and first/upper end **1049** of handle **1045** oriented down). A user grips handle **1045** by holding the handle **1045** in the palm of one’s hand and presses one’s thumb against arrow **1050** (with second/lower end **1047**/arrow **1050** facing up) for proper orientation of the handle **1045** during normal laryngoscopic use as shown in FIG. **1**. The first thumb location **1055** is located in elongate recessed region **1060**, near second/lower end **1047** of handle **1045**. In this position, the user’s thumb is collinear with and longitudinally aligned with the elongated recessed region **1060** and the handle **1045**. The handle **1045** includes a second thumb location **1065** at an opposite end of the elongate recessed region **1060**, near a first/upper end **1049** of the laryngoscope handle **1045**, which is engaged by the user’s thumb during more-delicate pediatric laryngoscopy. In this position, the user’s thumb is substantially perpendicular with the handle **1045**, giving the user a more delicate hold on the handle **1045** to help ensure that the child/toddler/baby is not injured during this more-delicate pediatric laryngoscopy procedure.

In the first laryngoscope orientation, the user wraps three fingers (one’s middle finger, third finger, and little finger) around and in three finger grip indents **1070, 1072, 1074**. The middle finger wraps around and in a first finger grip indent **1070** closest to second/lower end **1047** of handle **1045**, the third finger wraps around and in a second middle finger grip indent **1072** next closest to second/lower end **1047** of handle **1045**, and the little finger wraps around and in a third finger grip indent **1074** closest to first/upper end **1049** of handle **1045** (closest to where the blade connects to the handle **1045**). Because the user only grips the handle **1045** with three fingers (compared to gripping the handle **1005** of FIGS. **17-23** with four fingers), the user has a more delicate hold/grip on the handle **1045** and automatically provides less torque/leverage, which is appropriate for pediatric use. Thus, the handle **1045** shown in FIGS. **39A-39G** includes an ergonomic design that provides a proper angle for mandible lift and tongue sweep used in pediatric laryngoscopy, and helps to ensure the right amount of torque/leverage in child laryngoscopy to prevent fulcruming and breaking teeth.

With reference to FIGS. **24** and **25**, another embodiment of a laryngoscope **1100** similar to that shown in FIGS. **17-23** will be described. The above descriptions of the laryngoscopes, blades, handles and light sources are incorporated herein. The laryngoscope **1100** includes a handle **1110** and a blade **1120** that carries a proximal white light source **1150** and a distal black light source **1160**. The handle **1110** and the blade **1120** include an electrical circuit **1165** that includes a power source **1170**, a resistor **1180**, a resistor **1190**, the proximal white light source **1150**, and the distal black light source **1160**.

In the embodiment shown, the white light source **1150** is a cool white LED, with a mcd rating of 100-10,000 millicandela (mcd). In the embodiment shown, the resistor **1190** is a 150 ohm resistor behind the white light source to provide 5 ma at 2.9 volts. This brightness of the white light source **1150** of the proximal white light source **1150** is bright enough to provide general illumination (e.g., of the interior of the mouth and back of the patient’s throat) while not being so bright as to overtake the effects of the distal black light source **1160**.

In the embodiment shown, the distal black light source **1160** emits electromagnetic radiation including a wavelength in the range of 300 to 450 nm. In a more preferred embodiment, the distal black light source **1160** emits electromagnetic radiation including a wavelength in the range of 385 to 395 nm. In a most preferred embodiment, the distal black light source **1160** emits electromagnetic radiation including a wavelength at 395 nm. The electromagnetic radiation works with the body to help illuminate "vocal cords" or "vocal folds".

The combination of the black light source **1160** and white light source **1150** as shown and described herein increases visualization of airway anatomy during laryngoscopy procedures. An advantage of locating the black light source **1160** distally of the white light source **1150** is that, in use, the proximal white light source **1150** provides general illumination (e.g., of the interior of the mouth and back of the patient's throat) while the distal black light source **1160**, which is disposed closer to the patient's vocal cords and the glottis, provides directed black light illumination of the patient's vocal cords and the glottis, prompting the visible effects of fluorescence and phosphorescence with respect to the patient's vocal cords and the glottis.

White incandescent light used in laryngoscopy in the past caused glare, excessive reflectivity, and less differentiation of tissues during procedures. The black light emitted from the black light source **1160**, and especially locating it distally of the white light source **1150** as shown/described, causes vocal cords to naturally phosphoresce, clearly identifying pathway to the trachea. The black light and white light combination lighting produces "near-3D optimization of viewing area, causing airway structures to stand out via precision-shadowing effect. The black light and white light wavelength mix dramatically improves discrimination of tissues, field of view, reduces glare and creates better depth perception in the airway.

In the embodiment shown, the resistor **1180** disposed in the handle **1110** is a 13 ohm resistor and the power source **1170** is a 3.6 volt lithium battery power source to provide the distal black light source **1160** at 49-50 ma at 3.6 volts.

FIG. **26** is an exemplary graph of Radiant Power versus Forward Current, FIG. **27** is an exemplary graph of Radiant Power versus Wave Length, FIG. **28** is an exemplary graph of Peak Wave Length versus Forward Current, and FIG. **29** is an exemplary graph of Radiant Power versus Time for the distal black light source **1160** of the laryngoscope **1000** shown in FIG. **24**. The above voltage, current, resistor, radiant power, and wave length values for the distal black light source **1160** are obtained from the graphs shown in FIGS. **26-29**.

In alternative embodiments, values for voltage, current, resistor, radiant power, wave length, and/or other values than those described and/or shown herein may be used.

FIG. **30** illustrates an embodiment of an introducer **1200** (e.g., endotracheal tube polyethylene introducer) that may be used with a black light source such as, but not limited to, the black light source **160**, **1160** of the laryngoscopes described and shown herein. The introducer **1200** includes a distal portion **1210**, an intermediate portion **1220**, and a proximal portion **1230**. Opposite ends of the introducer **1200** are smooth and, in the embodiment shown, the introducer **1200** has a length of 50-70 cm. One or more of the distal portion **1210**, the intermediate portion **1220**, and/or the proximal portion **1230** include a fluorescent/phosphorescent color/coating or other color/substance that is enhanced by the black light or that reacts to the black light emitted by the black light source **160**, **1160**. Thus, the entire introducer

1200 or portion(s) of the introducer **1200** includes a fluorescent/phosphorescent color/coating or other color/substance that is enhanced by or reacts to the black light source **160**, **1160** for increased visualization of placement of the introducer **1200** (e.g., endotracheal tube introducer) during the medical procedure (e.g., intubation). The introducer **1200** can be used for, but not by way of limitation, successful orotracheal intubation and endotracheal intubation. The fluorescent/phosphorescent coating on the introducer **1200** causes the introducer **1200** to naturally phosphoresce under black light, clearly identifying introducer tracking through the vocal cords into the trachea.

In alternative embodiments, other types of insertions other than those described/shown herein include a fluorescent/phosphorescent color/coating or other color/substance that is enhanced by or reacts to the black light source **160**, **1160** for increased visualization of placement of the insertion during the medical procedure.

In a further embodiment, a camera, scope, or other imaging/viewing device is used with the black light source **160**, **1160** for increased visualization during a medical procedure.

FIG. **31** illustrates an embodiment of a stylet **1300** (e.g., endotracheal tube stylet) that may be used with a black light source such as, but not limited to, the black light source **160**, **1160** of the laryngoscopes described and shown herein. The stylet **1300** includes a stylet body **1305** (See also FIGS. **32A**, **32B**) made of a malleable, coated wire that holds a formed shape to facilitate safe intubation. The stylet body **1305** includes a distal portion **1310**, an intermediate portion **1320**, and a proximal portion **1330**, and a plug connector **1340** slidably attached to the stylet body **1300**. In the embodiment shown, the stylet **1300** has a length of 32 cm and a 6-French size.

An embodiment of the plug connector **1340** is shown in more detail in FIGS. **33A**, **33B**, **33C**. The plug connector **1340** includes an upper circular flange portion **1342** having an outer diameter and a lower cylindrical plug portion **1344** having an outer diameter that is less than the outer diameter of the upper circular flange portion **1342**. The central cylindrical hole/bore **1350** extends through the plug connector **1340** and slidably receives the stylet body **1305**. An upper hole/bore **1360** extends into an upper part of the plug connector **1240** and a lower hole/bore **1370** extends into the lower part of the plug connector **1240**.

One or more of the distal portion **1310**, the intermediate portion **1320**, and/or the proximal portion **1330** include an illuminating material or substance such as a fluorescent/phosphorescent color/coating or other color/substance that is enhanced by the black light or that reacts to the black light emitted by the black light source **160**, **1160**. Thus, the entire stylet **1300** or portion(s) of the stylet **1300** includes a fluorescent/phosphorescent color/coating or other color/substance that is enhanced by or reacts to the black light source **160**, **1160** for increased visualization of placement of the stylet **1300** (or stylet **1300** and endotracheal intubation tube) during the medical procedure (e.g., intubation). The fluorescent/phosphorescent coating on the stylet **1300** causes the stylet **1300** to naturally phosphoresce under black light, clearly identifying stylet/intubation tube tracking through the vocal cords into the trachea.

FIGS. **34-36C** disclose another embodiment of a stylet **1300a** that is similar to the stylet **1300** described above except that it is a larger size (45 cm length, 8 French). Elements of the stylet **1300a** that are similar to the elements of the stylet **1300** are identified with the same reference number, but with an "a" suffix.

FIGS. 37A and 37B illustrate an embodiment of a movable, protective cuff sheath 1400 that covers a distal endotracheal tube cuff 1410 (FIG. 37A) including an expandable body (e.g., balloon) 1430 during insertion of an endotracheal tube 1420 (e.g., during intubation) and moves to a retracted position (FIG. 37B) once the endotracheal tube 1420 is in position to expand the expandable body 1430. The movable protective cuff sheath 1400 reduces the profile and visibility of the distal endotracheal tube cuff 1410 during intubation. The movable, protective sheath covering the expandable body 1430 (e.g., pre-inflated balloon) reduces the profile of the expandable body 1430/cuff 1410 and aids physical visibility down the airway during intubation. The movable, protective cuff sheath 1400 and/or distal endotracheal tube cuff 1410 includes a fluorescent/phosphorescent color/coating or other color/substance that is enhanced by or reacts to the black light source 160, 1160 to aid in visibility and positioning of the cuff 1410.

FIGS. 38A and 38B illustrate an embodiment of a low-profile, low-visibility distal endotracheal tube cuff 1510 to reduce profile and visibility during intubation. In one or more embodiments, the low-profile, low-visibility distal endotracheal tube cuff 1510 includes one or more of a low-profile expandable body material 1530 (e.g., lower-profile, more-compliant balloon material utilized that will lay flat against body 1540 of tube 1550 in non-inflated state), a low-profile expandable body (e.g., balloon) packing configuration, and/or an indented tube body 1540 in the balloon cuff region (e.g., addition of indentation of tube body or smaller diameter indented section 1550 versus larger diameter outer tube section 1560 to enable further profile reduction of the pre-inflated balloon) to reduce the cuff profile and aid physical visibility down the airway during intubation procedures. The expandable body material 1530 includes a diameter/dimension D2 that is less than the diameter/dimension D1 of the outer tube section 1560 in the collapsed condition shown in FIG. 38A, and includes a diameter/dimension D3 that is greater than the diameter/dimension D1 of the outer tube section 1560 in the expanded condition shown in FIG. 38B (the expandable body material 1530 is expanded to secure the cuff 1510 in position in passageway). The expandable body material 1530 includes a fluorescent/phosphorescent color/coating or other color/substance that is enhanced by or reacts to the black light source 160, 1160 to aid in visibility and positioning of the cuff 1510.

Compared to current ET tube designs, which include distal cuffs that, even in their non-inflated states, have a wide profile which impedes visibility of the vocal cords and surrounding anatomy during intubation, the low-profile, low-visibility distal endotracheal tube cuff 1510 reduces the cuff profile and aids physical visibility down the airway during intubation. The fluorescent/phosphorescent color/coating on the expandable body material 1530 is enhanced by or reacts to the black light source 160, 1160 to aid in visibility and positioning of the cuff 1510.

With reference to FIGS. 50A-C, an embodiment of a removable sheath 1600 for an endotracheal tube cuff 1610, which includes an expandable body (e.g., balloon) 1620, will be described. The endotracheal tube cuff 1610 and expandable body 1620 are disposed at a distal portion of an endotracheal tube 1630. The endotracheal tube 1630 includes an inflation mechanism 1635 for inflating (e.g., 10-12 cc of air) the expandable body 1620. The removable sheath 1600 includes a substantially tubular portion 1650 and a finger portion 1660 with a finger hole 1670 to receive a finger of a user for removing the substantially tubular portion 1650 of the sheath 1600 from the endotracheal tube

cuff 1610. The purpose of the removable sheath 1600 is to protect the expandable body 1620 of the cuff 1610 before use, to eliminate the need for pre-use inflation/testing/checking of the expandable body 1620, and, in one embodiment (e.g., FIG. 50B), as a possible site for a reservoir 1680 (e.g., lidocaine jelly reservoir, which may be popped opened/closed) for peruse applications of gels or medicine (e.g., lidocaine jelly or similar substance for lubrication of tube/cuff/expandable body) to the tube/cuff/expandable body.

FIGS. 39A-39G disclose another embodiment of laryngoscope handle that is especially advantageous when used in endotracheal intubation of children.

FIGS. 40A-49F disclose further embodiment of laryngoscope blades including proximal white light source and a distal black light source. The above descriptions of the laryngoscopes, blades, handles and light sources are incorporated herein.

FIGS. 40A-40F disclose an embodiment of a Size 00 Miller laryngoscope blade.

FIGS. 41A-41F disclose an embodiment of a Size 0 Miller laryngoscope blade.

FIGS. 42A-42G disclose an embodiment of a Size 1 Miller laryngoscope blade.

FIGS. 43A-43F disclose an embodiment of a Size 2 Miller laryngoscope blade.

FIGS. 44A-44G disclose an embodiment of a Size 3 Miller laryngoscope blade.

FIGS. 45A-45G disclose an embodiment of a Size 4 Miller laryngoscope blade.

FIGS. 46A-46F disclose an embodiment of a Size 1 Macintosh laryngoscope blade.

FIGS. 47A-47F disclose an embodiment of a Size 2 Macintosh laryngoscope blade.

FIGS. 48A-48F disclose an embodiment of a Size 3 Macintosh laryngoscope blade.

FIGS. 49A-49F disclose an embodiment of a Size 4 Macintosh laryngoscope blade.

FIGS. 51-52 disclose a modified laryngoscope blade 1800, in pieces (FIG. 51) and assembled (FIG. 52), having a distal blade portion 1820 and a proximal connector portion 1823 configured for attachment to handle 114 (FIG. 53) of the assembled laryngoscope 1900. Handle 114 and connector portion 1823 are identical or similar to the corresponding parts in the previous embodiments and are therefore not described in detail. In this embodiment, the laryngoscope blade is modified to include a combined illumination and imaging unit 1810 mounted about 2/3 along the longitudinal length of the blade portion 1820, closer to a distal end 1821 of the blade portion 1820 than a proximal end 1822 of the blade portion 1820, as best illustrated in FIG. 51. Unit 1810 comprises an imaging/viewing device 1825 such as a miniature video camera, a white light 1830, and an ultraviolet light 1835 which emits UV light of the same wavelength range as the previous embodiments. The imaging/viewing device 1825 allows for increased visualization into the trachea during medical procedures. In this embodiment, the ultraviolet light 1835, white light 1830 and camera 1825 form a single integral unit and are all located at the same distance relative to the distal end of the laryngoscope blade portion 1820. Example white light sources include, but not by way of limitation, a white LED, a white halogen light, and a white incandescent light. In one or more embodiments, the image signals from the imaging/viewing device 1825 are transmitted to a video output screen/display screen/monitor that is either integral with the blade portion

1820 and/or handle 114 or is separate from the laryngoscope (e.g., separate standalone monitor).

FIG. 53 illustrates a schematic depiction of the laryngoscope in FIGS. 51 and 52 being used to assist in removal of an obstruction or foreign object such as a marble 1845 from a patient's trachea 1850. A marble is used by way of example in FIG. 53, but a large range of different foreign objects including foods, toys and the like may potentially become stuck in a patient's trachea 1850 and partially or totally obstruct air flow to the lungs. The blade portion 1820 of the laryngoscope 1900 is shown placed in the mouth of a patient 112 for viewing the vocal cords adjacent the larynx and to aid in the removal of the foreign object 1845. The medical provider grips handle 114 while using blade portion 1820 to move the tongue and mandible 118 out of the way and permit viewing past the vocal cords into the trachea 1850 while attempting to remove the foreign object 1845. In this embodiment, if the foreign object 1845 has a phosphor content, the illumination of the foreign object 1845 by the two light sources is increased. The combination of the white light 1830 and UV light 1835 at an equal distance from the opening into the trachea 1850 helps to create a three dimensional image of the patient's airway, and may allow a medical provider to see, in a preferred embodiment, as deep as four circoird rings 1855, in an alternative preferred embodiment, as deep as three circoird rings 1855, in a further alternative preferred embodiment, as deep as two circoird rings 1855, and in a still further alternative preferred embodiment, as deep as one circoird ring 1855 into the trachea 1850. FIG. 53 illustrates foreign object 1845 trapped between the third and fourth circoird rings, which is a common location for trapped foreign objects in the trachea 1850. The UV light is absorbed by the tissues in the trachea 1850 around the obstruction, resulting in self-produced back light from the resultant UV light induced fluorescence and phosphorescence, while any phosphor content in the trapped object 1845 also results in phosphorescence which further illuminates the object 1845 and helps the provider in locating and attempting to remove the object 1845 using forceps 1860. The medical provider inserts the ends of forceps 1860 into the trachea 1850 while viewing the illuminated object 1845 directly or via a video output screen directly connected or wirelessly connected to camera 1825, and advances the ends of the forceps 1860 up to the object 1845. The combined white and UV light sources 1830, 1835 together with the camera 1825 significantly improve visibility of the trapped object 1845, similarly increasing the likelihood of the provider being able to grasp and retrieve the object 1845 from the trachea 1850 using forceps 1860 or similar retrieval instruments. The UV light helps to create a three dimensional view inside the patient's mouth and trachea 1850, and also significantly reduces glare.

Although the forceps 1860 shown in FIG. 53 are Magill-type forceps, in alternative embodiments, other types of forceps, including but not limited to forceps with jaws coated with a fluorescent material, may be used. When forceps 1860 with coated jaws are used, the fluorescent colored material is enhanced by the fluorescent/black light, allowing the user to see exactly where to grab the object and, most importantly, not cause damage to surrounding tissue.

FIG. 54 is a combination ultraviolet/black light and white light source 1872 that includes epoxy holding compartments 1870, 1871 that contain a white light source 1875 and a fluorescent/UV/black light source 1880, respectively. The light sources 1875, 1880 and epoxy holding compartments 1870, 1871 are integrated together into a single unit/package. This combination light source 1872 can be used in place

of the separate black/fluorescent light source and white light source in the embodiment of FIGS. 51 to 53 or in any of the previous embodiments. In this device, the white light source 1875 can be a white LED diode and the ultraviolet light source 1880 can be an ultraviolet diode.

The above figures may depict exemplary configurations for the invention, which is done to aid in understanding the features and functionality that can be included in the invention. The invention is not restricted to the illustrated architectures or configurations, but can be implemented using a variety of alternative architectures and configurations. Additionally, although the invention is described above in terms of various exemplary embodiments and implementations, it should be understood that the various features and functionality described in one or more of the individual embodiments with which they are described, but instead can be applied, alone or in some combination, to one or more of the other embodiments of the invention, whether or not such embodiments are described and whether or not such features are presented as being a part of a described embodiment. Thus the breadth and scope of the present invention, especially in the following claims, should not be limited by any of the above-described exemplary embodiments.

Terms and phrases used in this document, and variations thereof, unless otherwise expressly stated, should be construed as open ended as opposed to limiting. As examples of the foregoing: the term "including" should be read as meaning "including, without limitation" or the like; the term "example" is used to provide exemplary instances of the item in discussion, not an exhaustive or limiting list thereof; and adjectives such as "conventional," "traditional," "standard," "known" and terms of similar meaning should not be construed as limiting the item described to a given time period or to an item available as of a given time, but instead should be read to encompass conventional, traditional, normal, or standard technologies that may be available or known now or at any time in the future. Likewise, a group of items linked with the conjunction "and" should not be read as requiring that each and every one of those items be present in the grouping, but rather should be read as "and/or" unless expressly stated otherwise. Similarly, a group of items linked with the conjunction "or" should not be read as requiring mutual exclusivity among that group, but rather should also be read as "and/or" unless expressly stated otherwise. Furthermore, although items, elements or components of the disclosure may be described or claimed in the singular, the plural is contemplated to be within the scope thereof unless limitation to the singular is explicitly stated. The presence of broadening words and phrases such as "one or more," "at least," "but not limited to" or other like phrases in some instances shall not be read to mean that the narrower case is intended or required in instances where such broadening phrases may be absent.

We claim:

1. A device for use in the performance of an endotracheal intubation, comprising:

a laryngoscope blade having a proximate portion and a distal portion with a distal end, the laryngoscope blade connectable to a laryngoscope handle through a connection section;

at least two different light sources carried by the laryngoscope blade and in equal distance from the distal end of the laryngoscope blade, the two light sources comprising an ultraviolet light source and a white light source that, in combination, allows for the illumination of ultraviolet light being absorbed and self promotes back light from phosphorous reactions; and

an imaging device carried by the laryngoscope blade a distance from the distal end that is substantially equal to the distance between the distal end and the ultraviolet light source and the white light source,

wherein the ultraviolet light source and the white light source include ends that light is emitted from, and the light sources are *stacked white light and ultraviolet light LEDs* combined into a single integrated unit including epoxy holding compartments that contain the white light source and the ultraviolet light source, the epoxy holding compartments integrated together into a single unit and including epoxy extending beyond the ends of the ultraviolet light source and the white light source *so that the epoxy holding compartments form an external dual-domed configuration.*

2. The device of claim 1, further comprising an electrical circuit including a 3.6-4.5 volt lithium battery power source in the laryngoscope handle.

3. The device of claim 1, wherein the connection section is configured to cause the light sources to be automatically activated when the laryngoscope blade is connected to the laryngoscope handle.

4. The device of claim 3, wherein the connection section is configured to cause the imaging device to be automatically activated when the laryngoscope blade is connected to the laryngoscope handle.

5. The device of claim 1, wherein the imaging device is a camera head.

6. The device of claim 1, wherein the ultraviolet light source emits electromagnetic radiation having a wavelength in the range of 300 to 450 nm.

7. The device of claim 1, wherein the white light is a 2-8 mm LED diode.

8. The device of claim 1, wherein the white light is a cool white LED with a rating of 100-10,000 millicandela (mcd).

9. The device of claim 1, wherein the ultraviolet light is an ultraviolet diode.

10. A method of performing direct laryngoscopy, comprising:

connecting the laryngoscope blade of claim 1 and a laryngoscope handle to create a laryngoscope;

using the laryngoscope to lift a patient's tongue and mandible for locating and/or viewing a foreign object in the patient;

providing the two light sources to:

prompt a visible illumination effect in the patient's epiglottis and vocal cords resulting from: the absorption of some or all of the ultraviolet light by tissues in the patient; and a self-providing back light from phosphorus reactions; and

allow a reaction with a foreign body in the patient; and locating the foreign object in the patient.

11. A laryngoscope for use in viewing the vocal chords and trachea of a patient while performing endotracheal intubation or attempting to remove a foreign body obstructing the trachea, comprising:

a laryngoscope handle adapted for gripping by a user; a laryngoscope blade having a proximal portion configured for connection to the laryngoscope handle and a distal portion configured for insertion into a patient's mouth into an operative position, the distal portion having a distal end facing an opening of the trachea in the operative position;

at least two different light sources carried by the laryngoscope blade and both located at a first distance from the distal end of the laryngoscope blade, the at least two light sources comprising an ultraviolet (UV) light

source and a white light source, the light sources *being stacked white light and ultraviolet light LEDs and* together configured to provide illumination in a portion of the trachea extending from the trachea opening, and the UV light source configured to prompt the visible effects of fluorescence and phosphorescence in illuminated tissues in the trachea and to produce phosphorescence from absorption of UV light in a foreign body having a phosphor content located in the illuminated portion of the trachea; and

an imaging device carried by the laryngoscope blade and configured to produce an image of the illuminated portion of the trachea and any foreign object obstructing the illuminated portion,

wherein the light sources are combined into a single integrated unit including epoxy holding compartments that contain the white light source and the ultraviolet light source, the epoxy holding compartments integrated together into a single unit [and each epoxy holding compartment including a domed configuration] *so that the epoxy holding compartments form an external dual-domed configuration.*

12. The device of claim 11, wherein the imaging device is at substantially the same distance from distal end as the light sources.

13. The device of claim 12, wherein the light sources and imaging device are in a single unit mounted in the distal portion of the blade.

14. A method of retrieving a foreign object from a patient's trachea, comprising:

illuminating both of the light sources of the laryngoscope of claim 11;

inserting the distal portion of the laryngoscope into a patient's mouth over a patient's tongue and mandible and into the throat area to an operative position in which a portion of the trachea extending from the vocal cords is illuminated by the light sources and the UV light source prompts the visible effects of fluorescence and phosphorescence in the tissue of the illuminated portion of the trachea and UV light is absorbed by any phosphor content in a foreign object trapped in the illuminated portion of trachea to produce phosphorescence to further illuminate the object;

inserting ends of forceps into the trachea and advancing the ends of the forceps towards the illuminated object while viewing the illuminated object to aid in locating the object with the forceps; and

retrieving the object from the trachea using the forceps.

15. The method of claim 14, wherein the imaging device is a camera head, and the method further comprises viewing the object with the camera head.

16. The method of claim 14, wherein the method further comprises viewing the object as deep as one circoid ring into the trachea.

17. The method of claim 14, wherein the method further comprises viewing the object as deep as two circoid rings into the trachea.

18. The method of claim 14, wherein the method further comprises viewing the object as deep as three circoid rings into the trachea.

19. The method of claim 14, wherein the method further comprises viewing the object as deep as four circoid rings into the trachea.

20. *A device for use in the performance of an endotracheal intubation, comprising:*

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a laryngoscope blade having a proximate portion and a distal portion with a distal end, the laryngoscope blade connectable to a laryngoscope handle through a connection section;

at least two different light sources carried by the laryngoscope blade, the two light sources comprising an ultraviolet light source and a white light source that, in combination, allows for the illumination of ultraviolet light being absorbed and self promotes back light from phosphorous reactions,

wherein the ultraviolet light source and the white light source are stacked white light and ultraviolet light LEDs and include ends that light is emitted from and are combined into a single integrated unit including epoxy holding compartments that contain the white light source and the ultraviolet light source, the epoxy holding compartments integrated together into a single unit and including epoxy extending beyond the ends of the ultraviolet light source and the white light source so that the epoxy holding compartments form an external dual-domed configuration.

21. *The device of claim 20, wherein the ultraviolet light source and the white light source are in equal distance from the distal end of the laryngoscope blade.*

22. *The device of claim 20, wherein each epoxy holding compartment includes a domed configuration.*

23. *A laryngoscope for use in viewing the vocal chords and trachea of a patient while performing endotracheal intubation or attempting to remove a foreign body obstructing the trachea, comprising:*

a laryngoscope handle adapted for gripping by a user;
a laryngoscope blade having a proximal portion configured for connection to the laryngoscope handle and a

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distal portion configured for insertion into a patient's mouth into an operative position, the distal portion having a distal end facing an opening of the trachea in the operative position;

at least two different light sources carried by the laryngoscope blade and both located at a distance from the distal end of the laryngoscope blade, the at least two light sources comprising an ultraviolet (UV) light source and a white light source, the light sources being stacked white light and ultraviolet light LEDs and together configured to provide illumination in a portion of the trachea extending from the trachea opening, and the UV light source configured to prompt the visible effects of fluorescence and phosphorescence in illuminated tissues in the trachea and to produce phosphorescence from absorption of UV light in a foreign body having a phosphor content located in the illuminated portion of the trachea,

wherein the light sources are combined into a single integrated unit including epoxy holding compartments that contain the white light source and the ultraviolet light source, the epoxy holding compartments integrated together into a single unit so that the epoxy holding compartments form an external dual-domed configuration.

24. *The device of claim 23, wherein the epoxy holding compartments include epoxy extending beyond the ends of the ultraviolet light source and the white light source.*

25. *The device of claim 23, wherein the ultraviolet light source and the white light source are spaced an equal distance from the distal end of the laryngoscope blade.*

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