



US 20200297357A1

(19) **United States**

(12) **Patent Application Publication**
Cameron et al.

(10) **Pub. No.: US 2020/0297357 A1**

(43) **Pub. Date: Sep. 24, 2020**

(54) **SYSTEM FOR NEURONAVIGATION
REGISTRATION AND ROBOTIC
TRAJECTORY GUIDANCE, ROBOTIC
SURGERY, AND RELATED METHODS AND
DEVICES**

Publication Classification

- (51) **Int. Cl.**
A61B 17/16 (2006.01)
A61B 34/30 (2006.01)
A61B 17/17 (2006.01)
A61B 34/20 (2006.01)
A61B 90/14 (2006.01)
A61B 90/00 (2006.01)
A61B 90/11 (2006.01)
- (52) **U.S. Cl.**
 CPC *A61B 17/1695* (2013.01); *A61B 34/30*
 (2016.02); *A61B 17/1739* (2013.01); *A61B*
34/20 (2016.02); *A61B 90/14* (2016.02); *A61B*
2017/00407 (2013.01); *A61B 90/08* (2016.02);
A61B 90/11 (2016.02); *A61B 17/162*
 (2013.01); *A61B 2090/034* (2016.02); *A61B*
2090/0807 (2016.02); *A61B 90/03* (2016.02)

(71) Applicant: **GLOBUS MEDICAL, INC.**, Audubon,
PA (US)

(72) Inventors: **Hayden Cameron**, Philadelphia, PA
(US); **Spiros Mantzavinos**, Nashua,
NH (US); **Neil R. Crawford**, Chandler,
AZ (US); **Sanjay Joshi**, Andover, MA
(US); **Norbert Johnson**, North
Andover, MA (US); **James Cascarano**,
Cambridge, MA (US); **Justin Larson**,
Somerville, MA (US); **Stephen**
Cicchini, North Wales, PA (US); **Ross**
Morris, Norristown, PA (US);
Christopher Angelucci, Schwenksville,
PA (US)

(21) Appl. No.: **16/695,310**

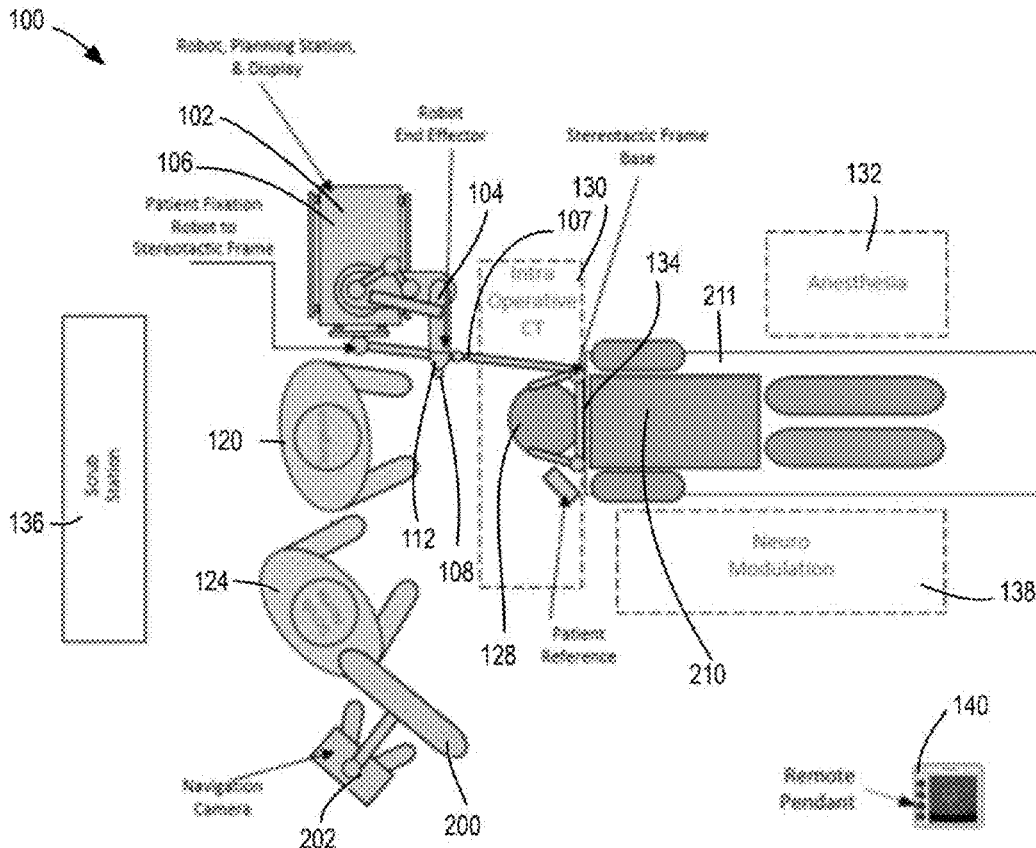
(22) Filed: **Nov. 26, 2019**

Related U.S. Application Data

(63) Continuation-in-part of application No. 16/452,737,
filed on Jun. 26, 2019, which is a continuation-in-part
of application No. 16/361,863, filed on Mar. 22, 2019.

(57) **ABSTRACT**

A system for robotic surgery makes use of an end-effector which has been configured so that a drill connected thereto is guided in its trajectory and limited in its advancement into an associated anatomical feature by a drill guide. The drill guide may be adjusted manually to engage a corresponding surface of the drill after its advancement by a pre-selected amount. The drill guide likewise includes features to guide the drill during trajectories having oblique angles relative to the surface of the anatomical feature associated with the medical procedure.



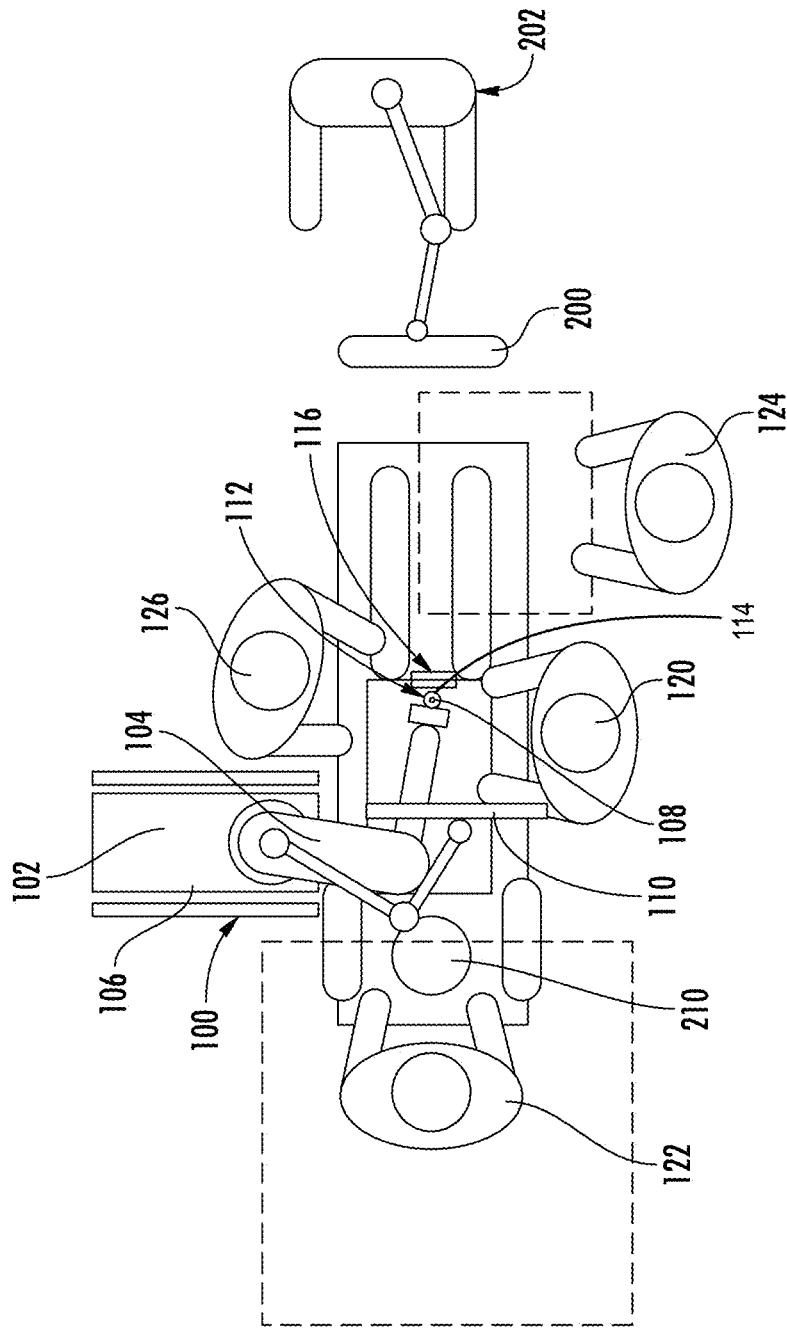


FIG. 1A

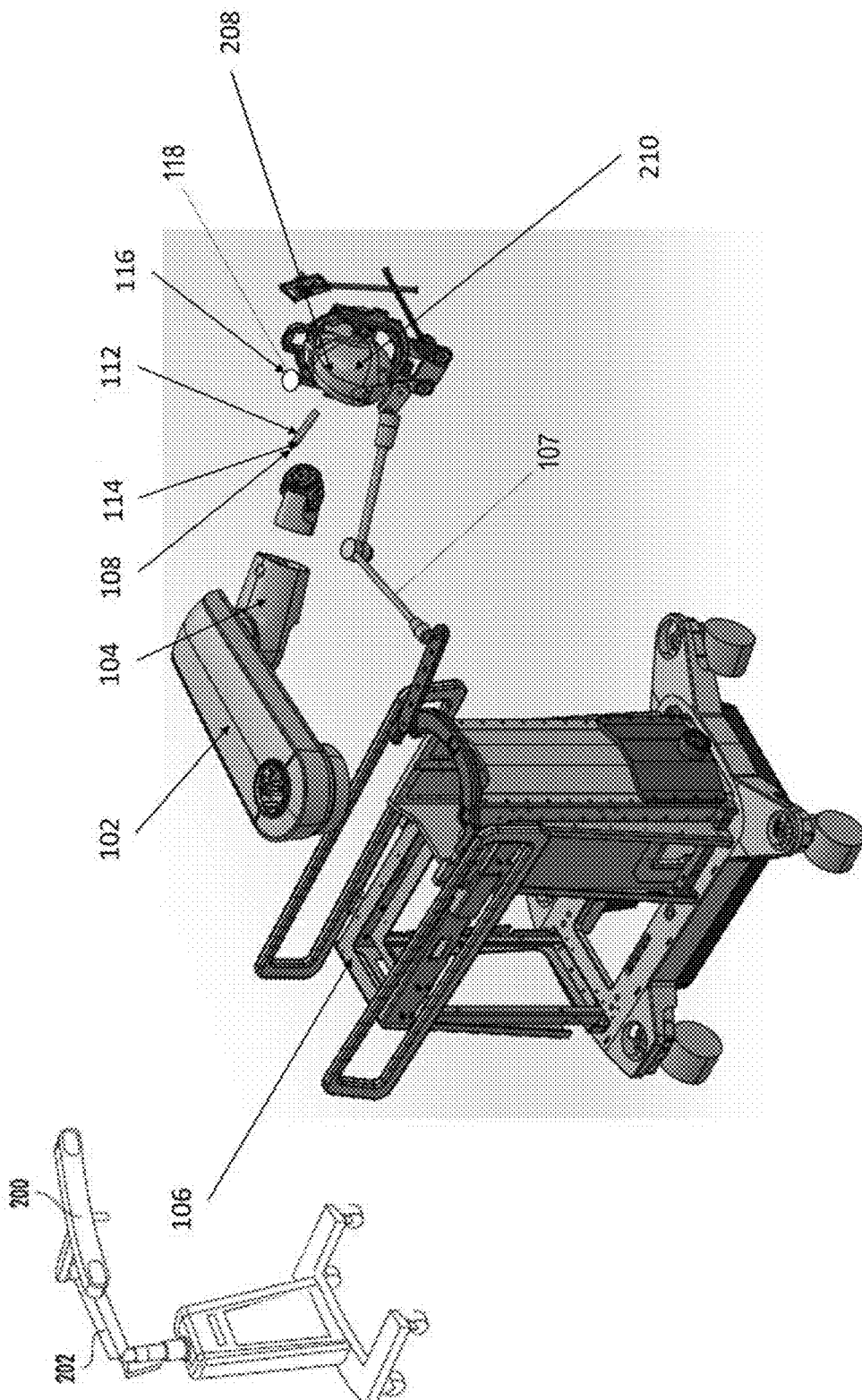


FIG. 2

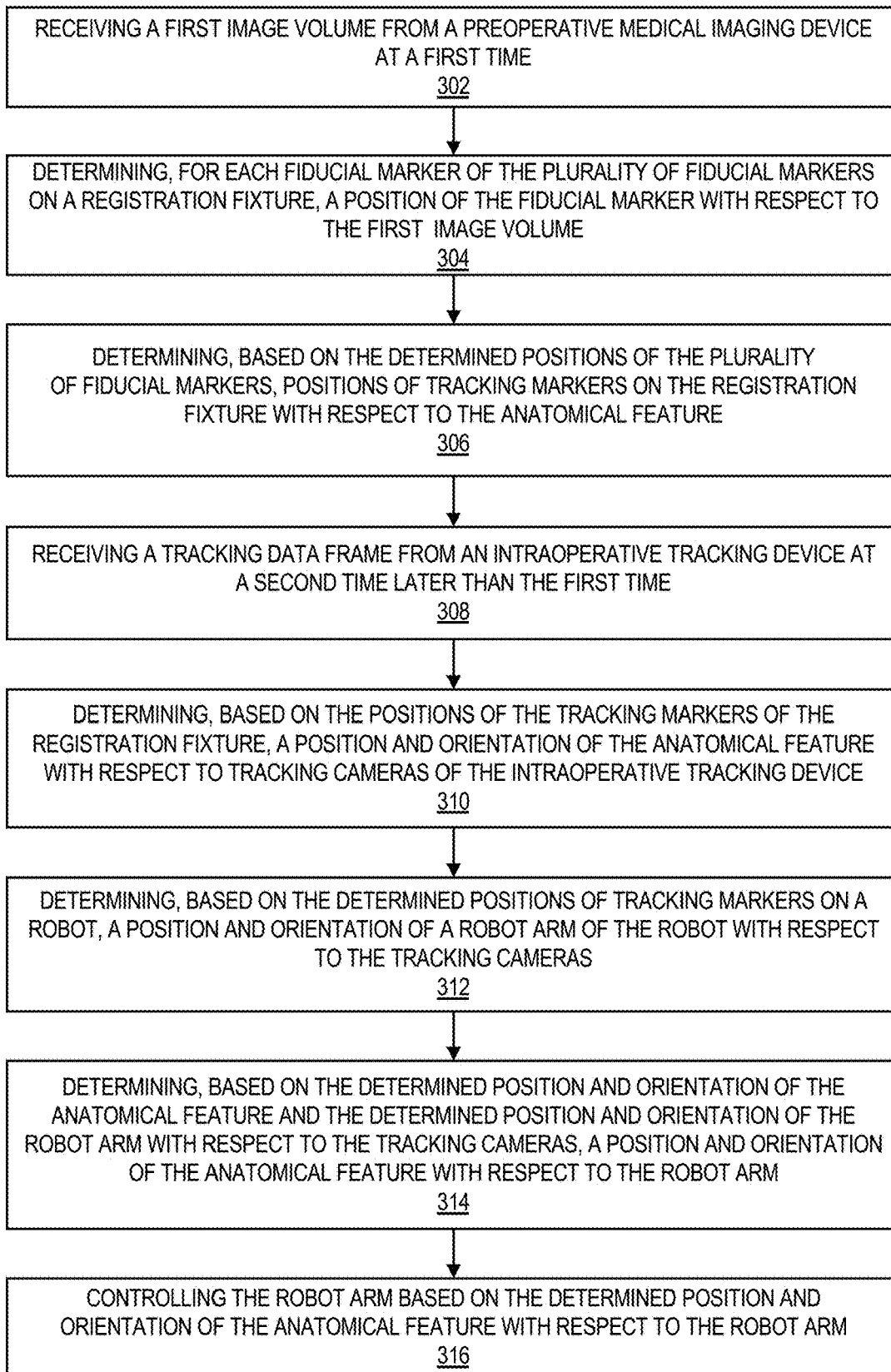


FIG. 3

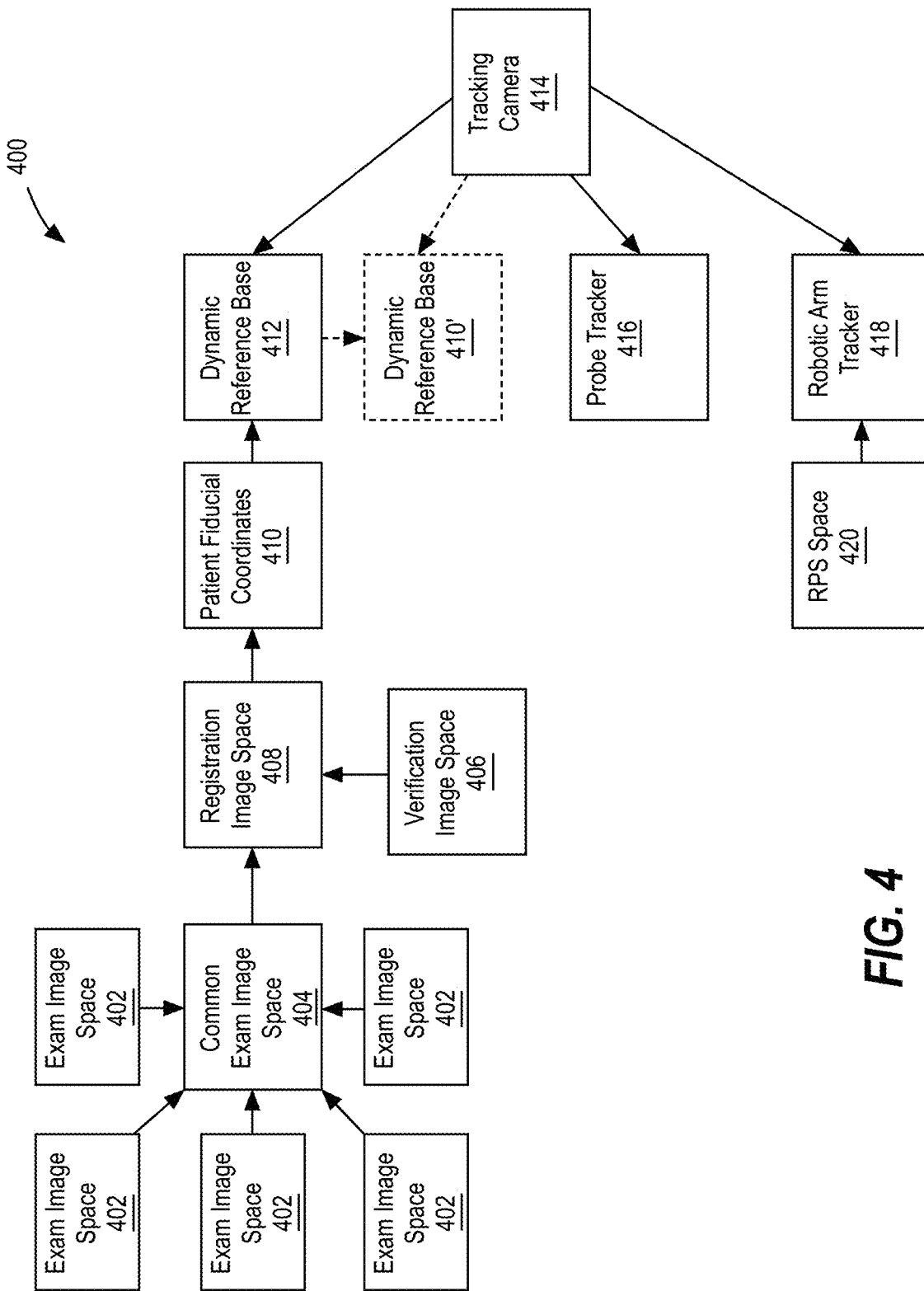


FIG. 4

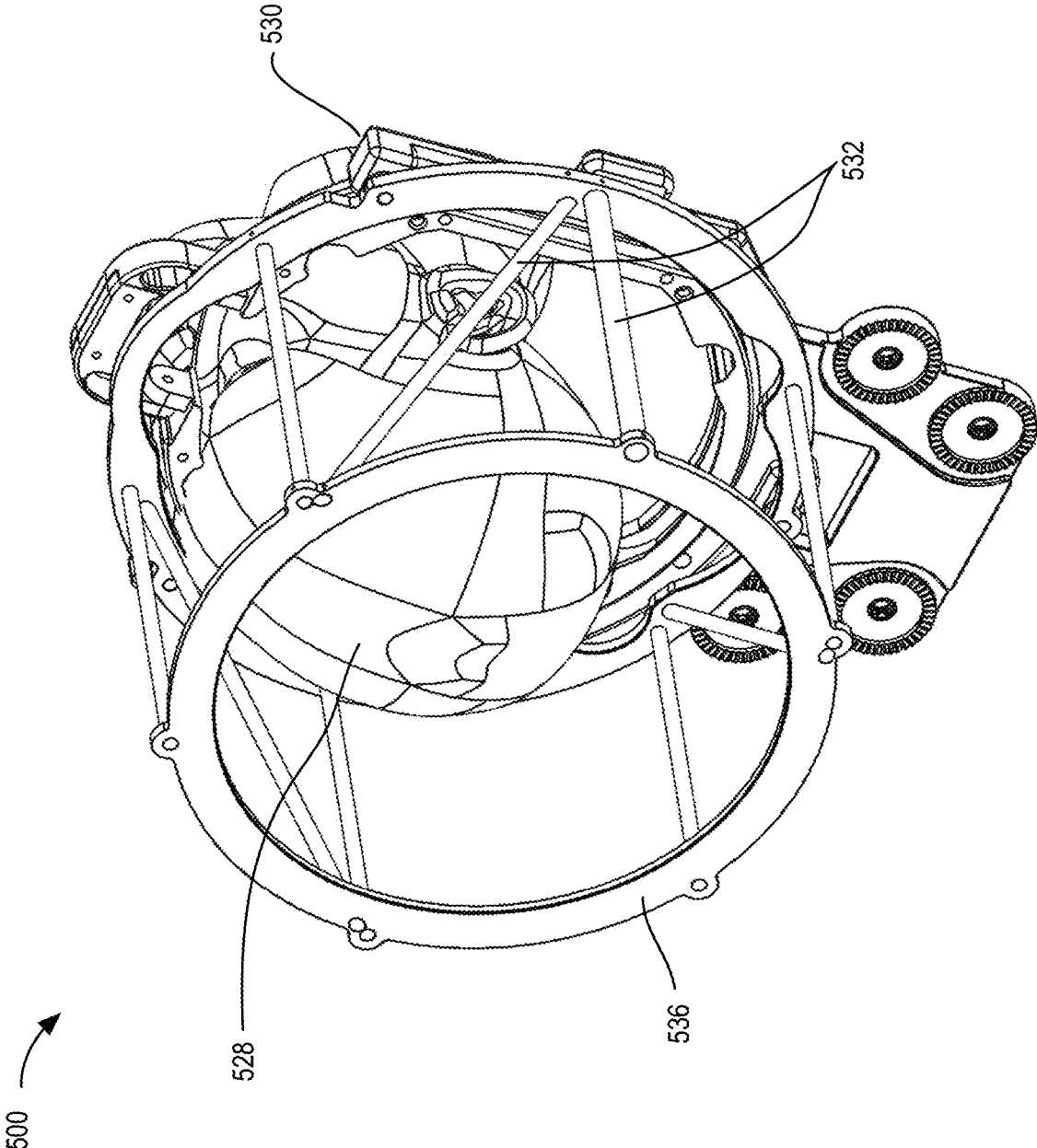


FIG. 5A

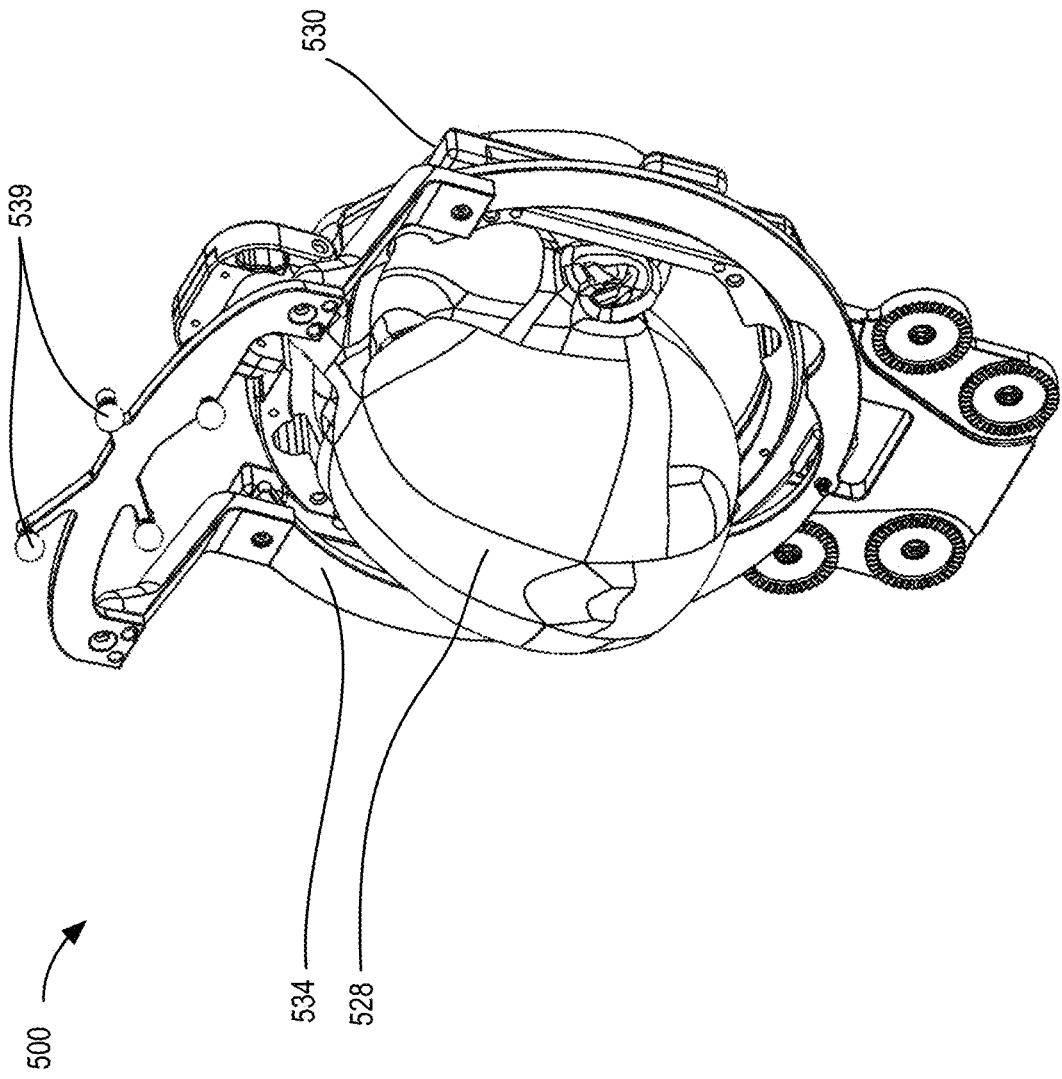


FIG. 5B

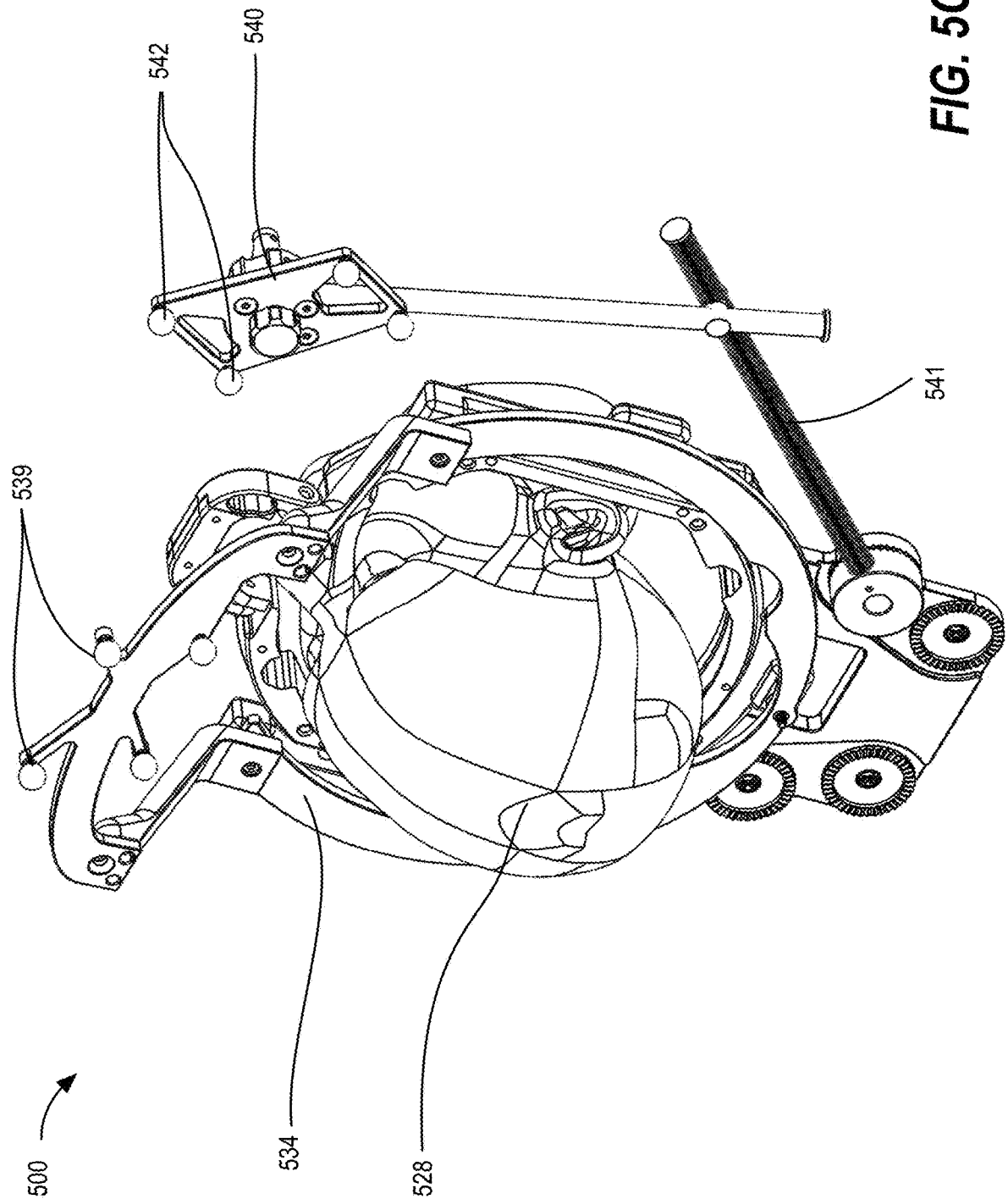


FIG. 5C

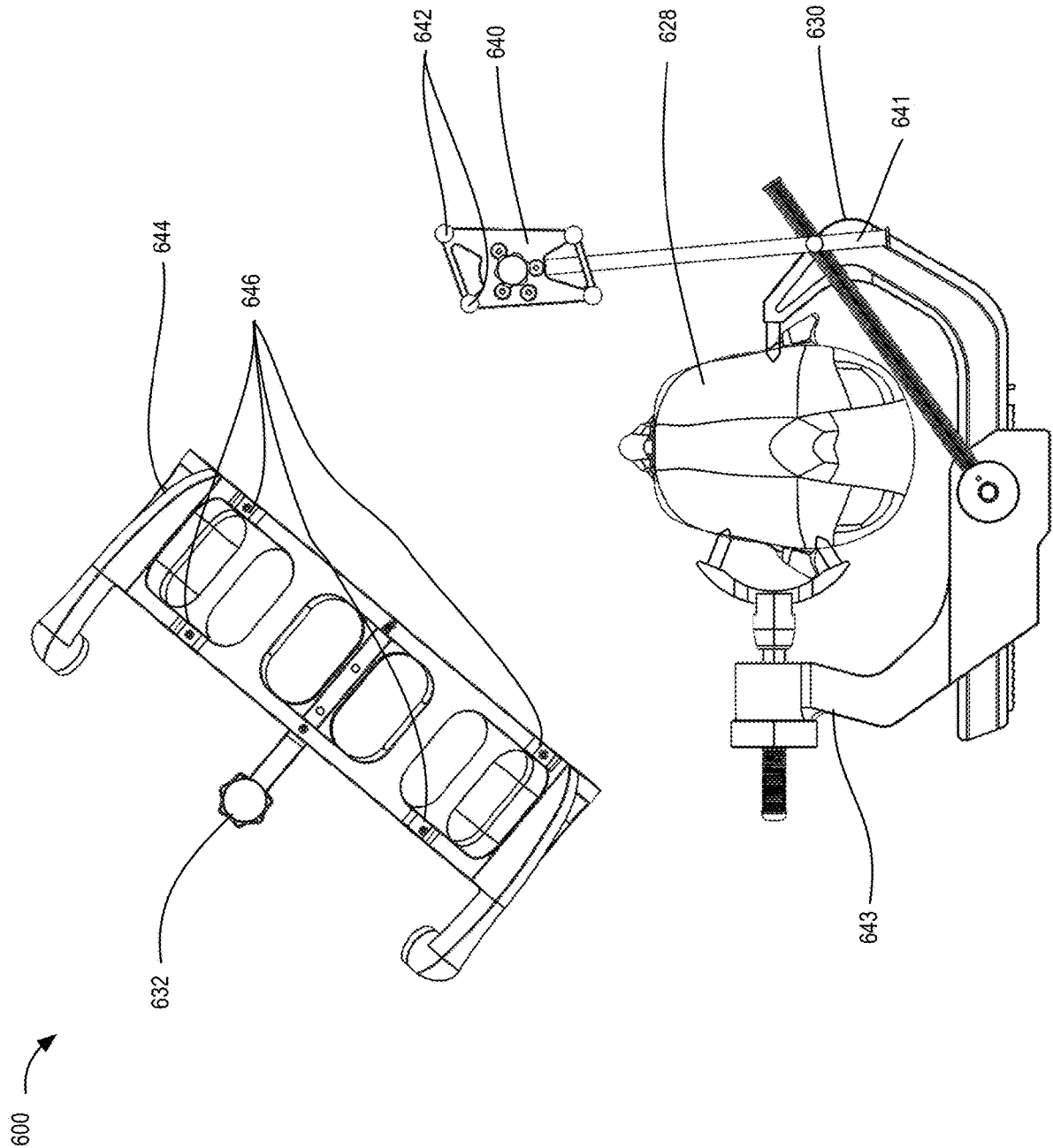
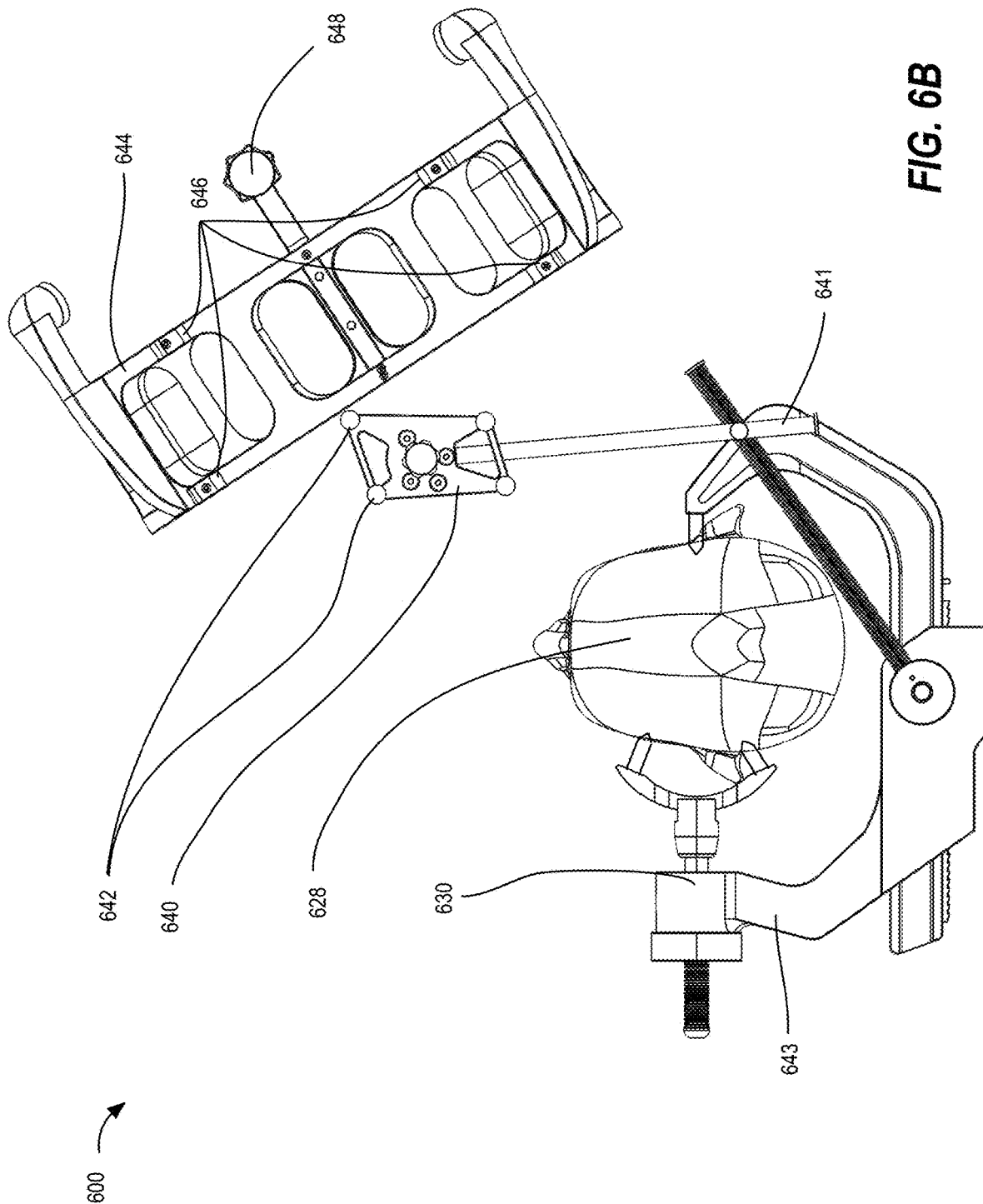


FIG. 6A



700 →

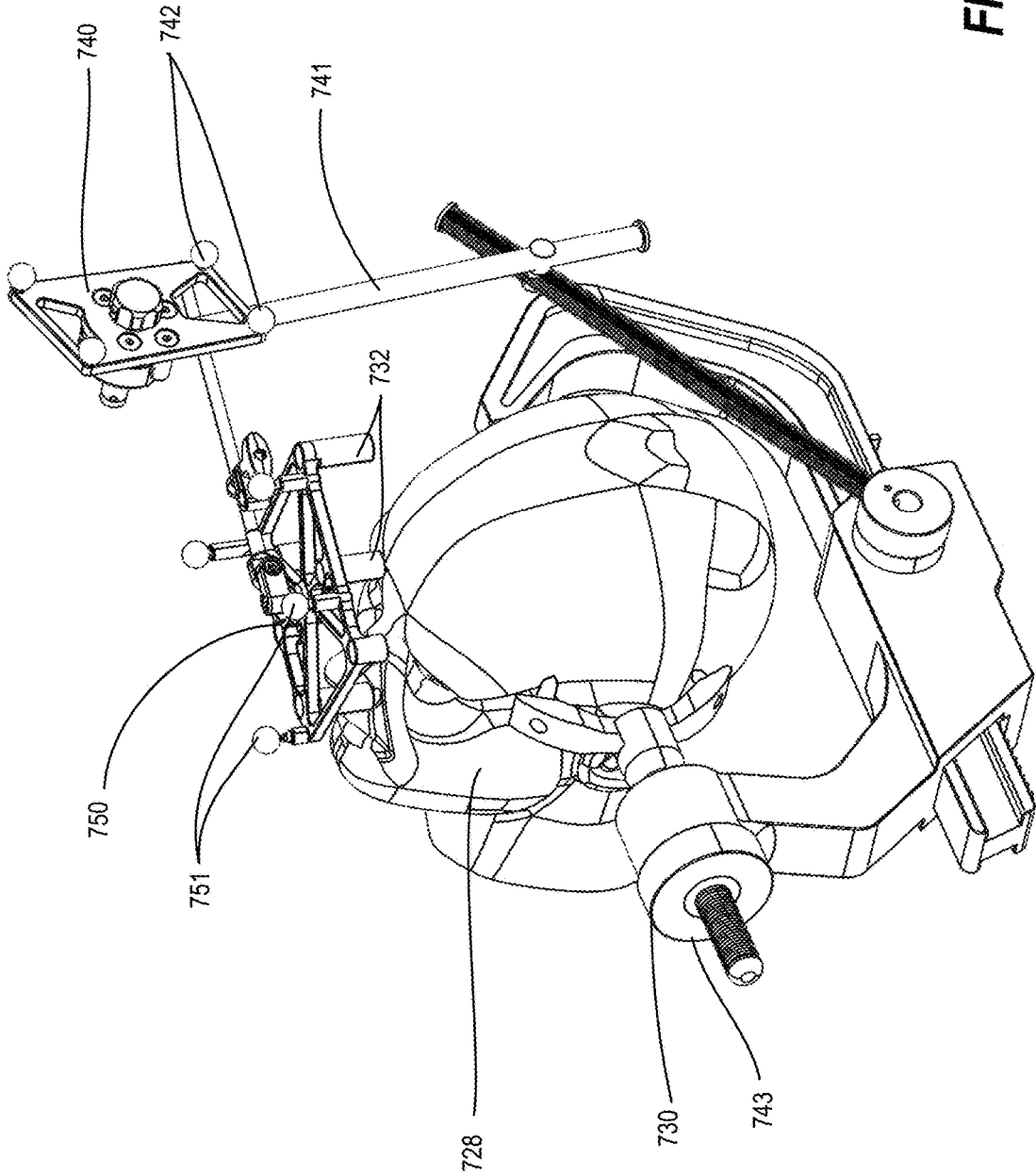
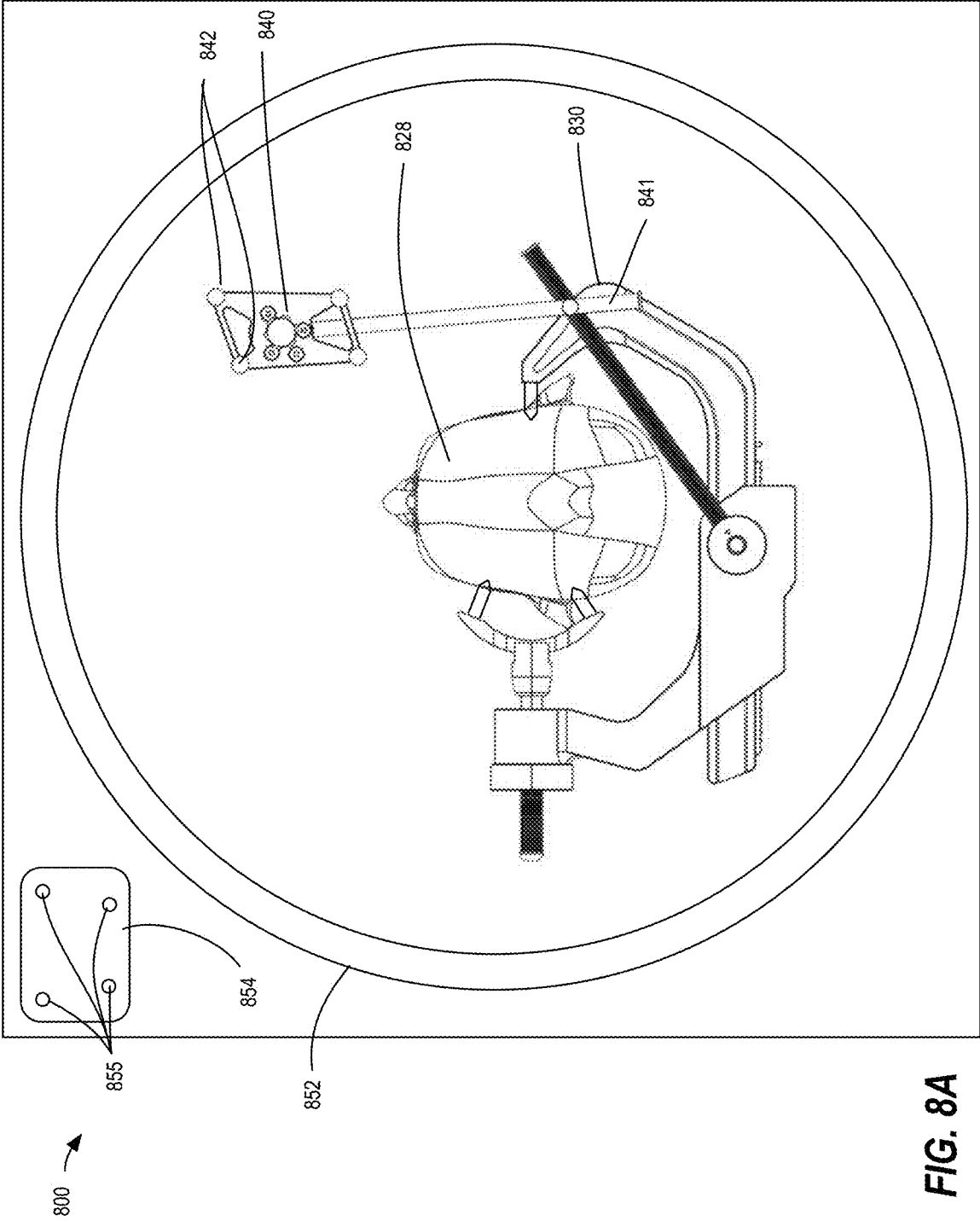


FIG. 7



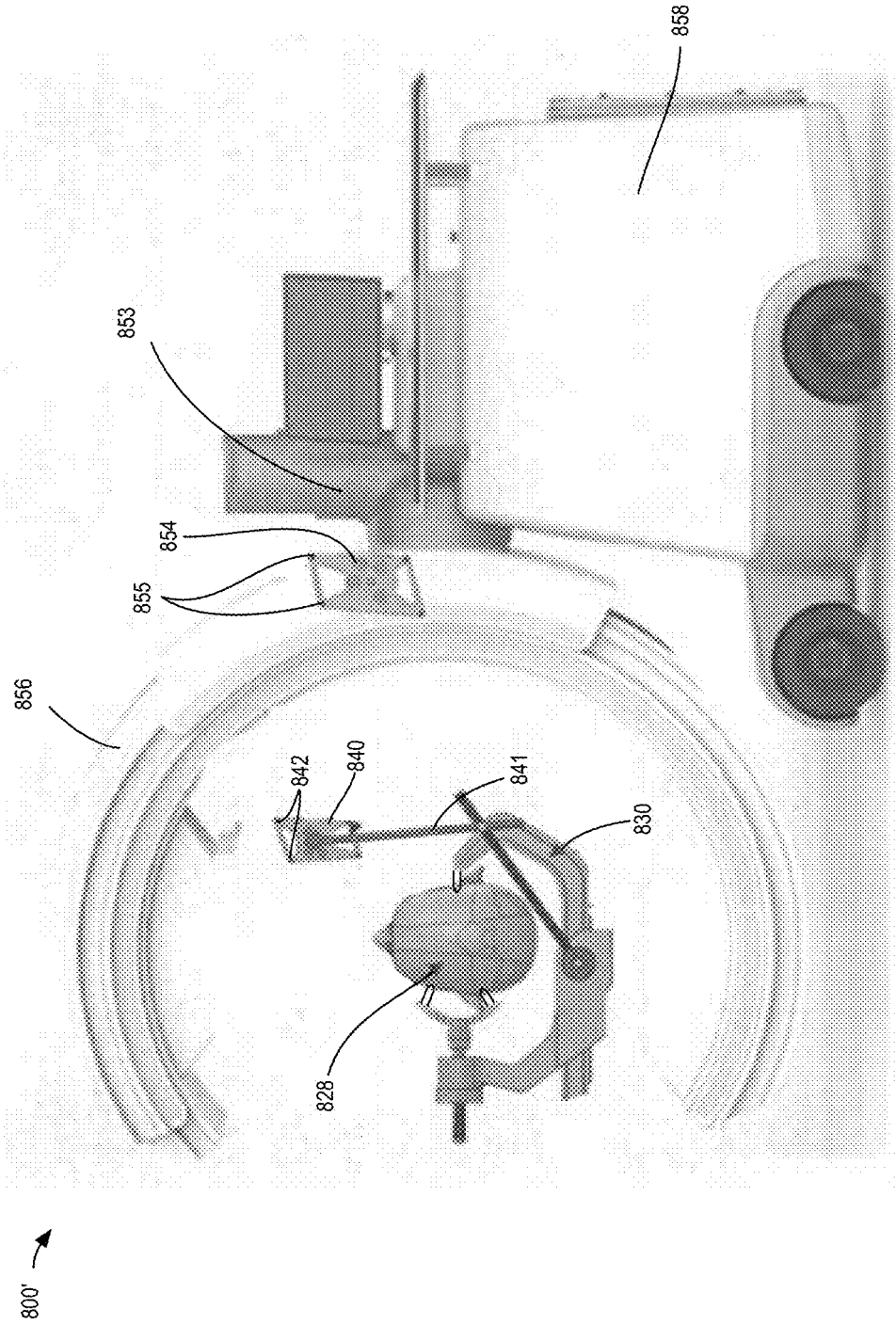


FIG. 8B

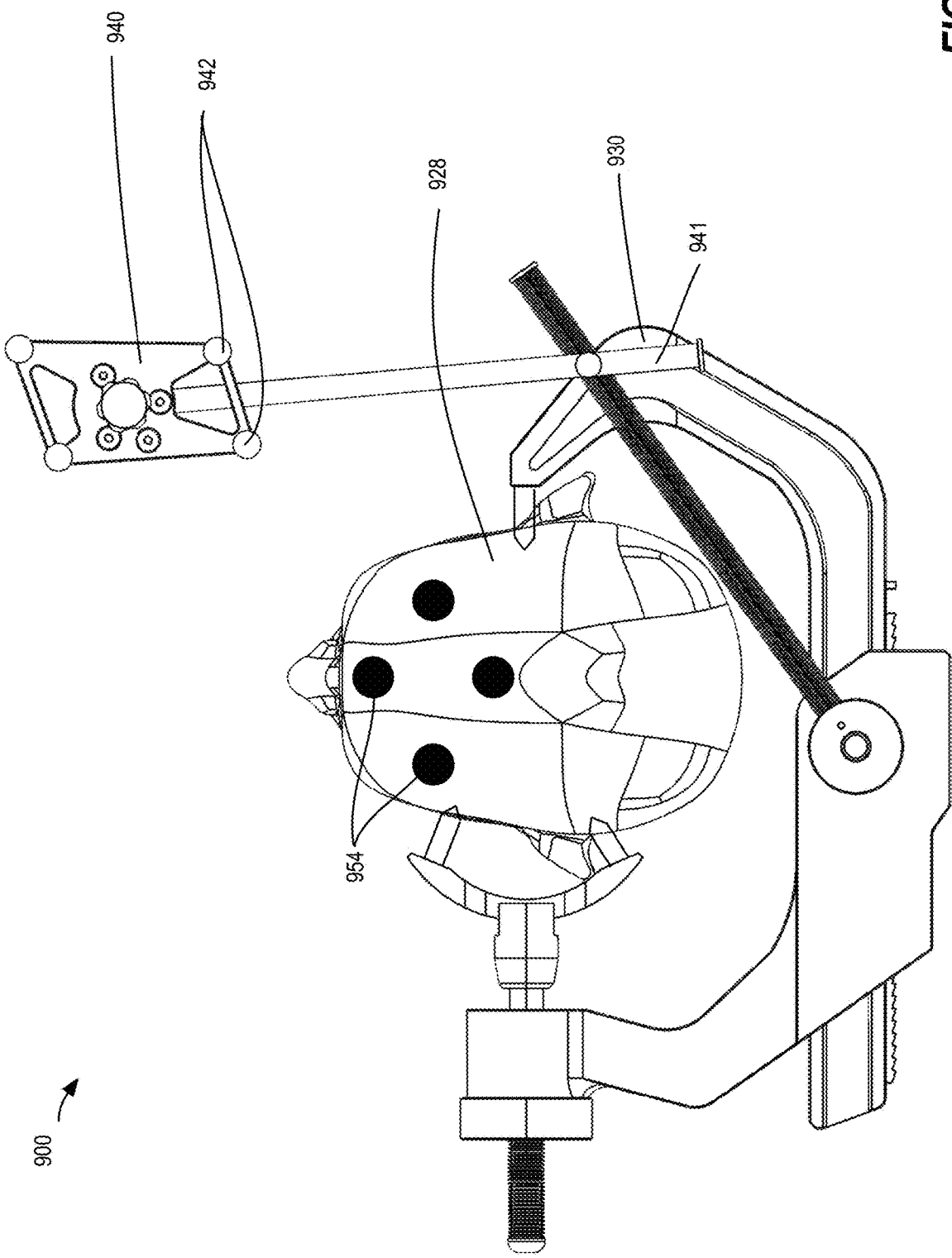


FIG. 9

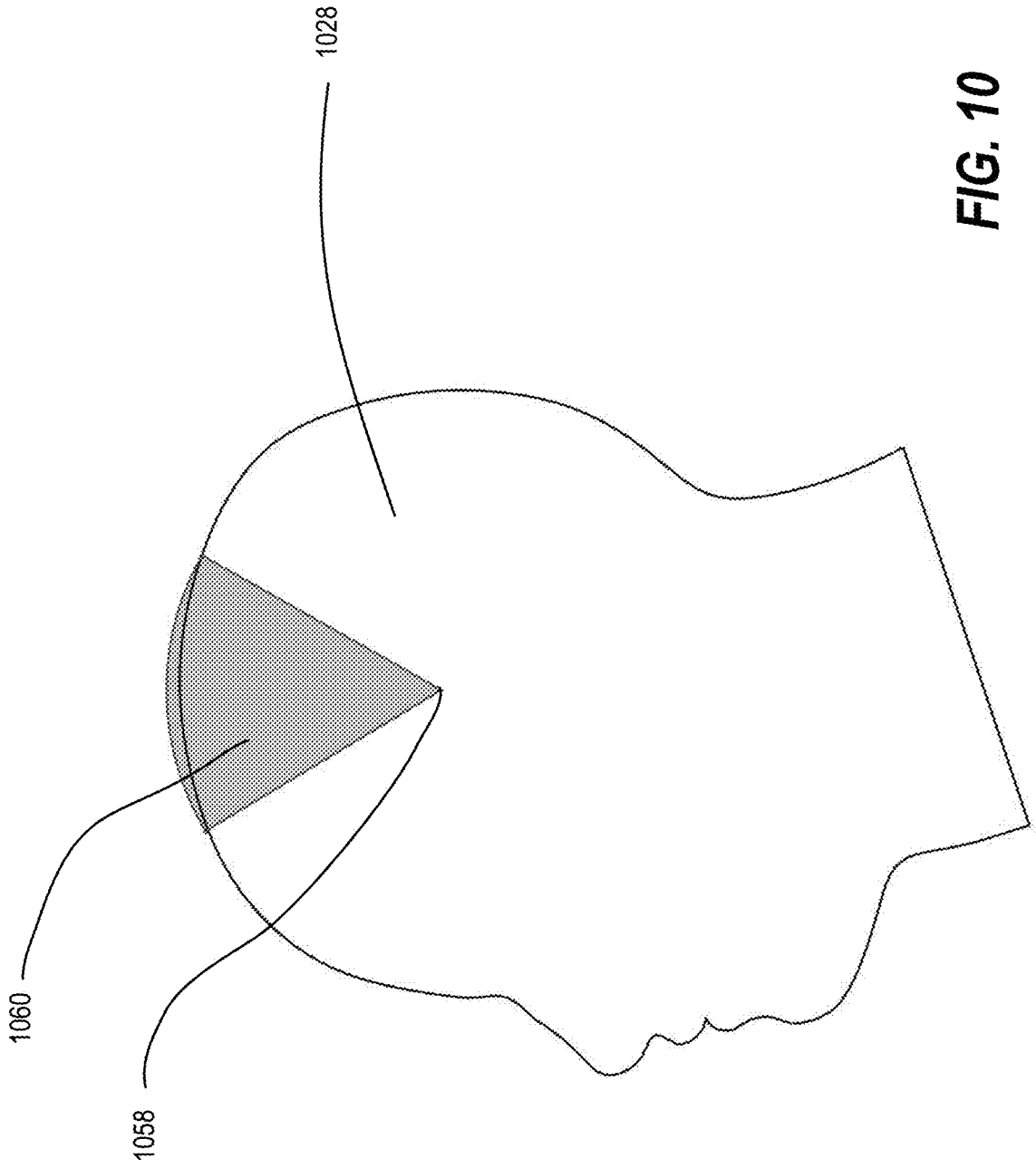


FIG. 10

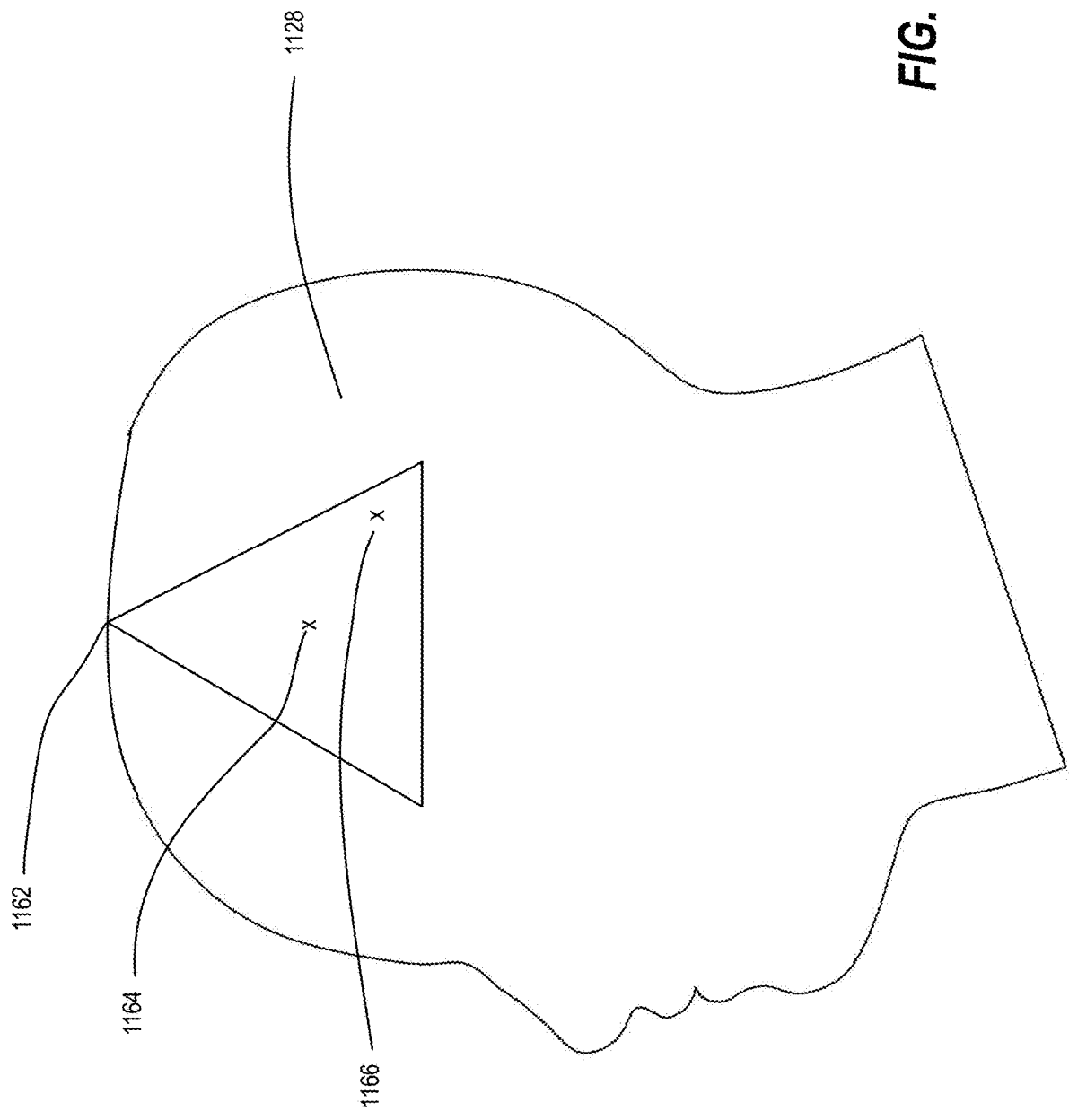


FIG. 11

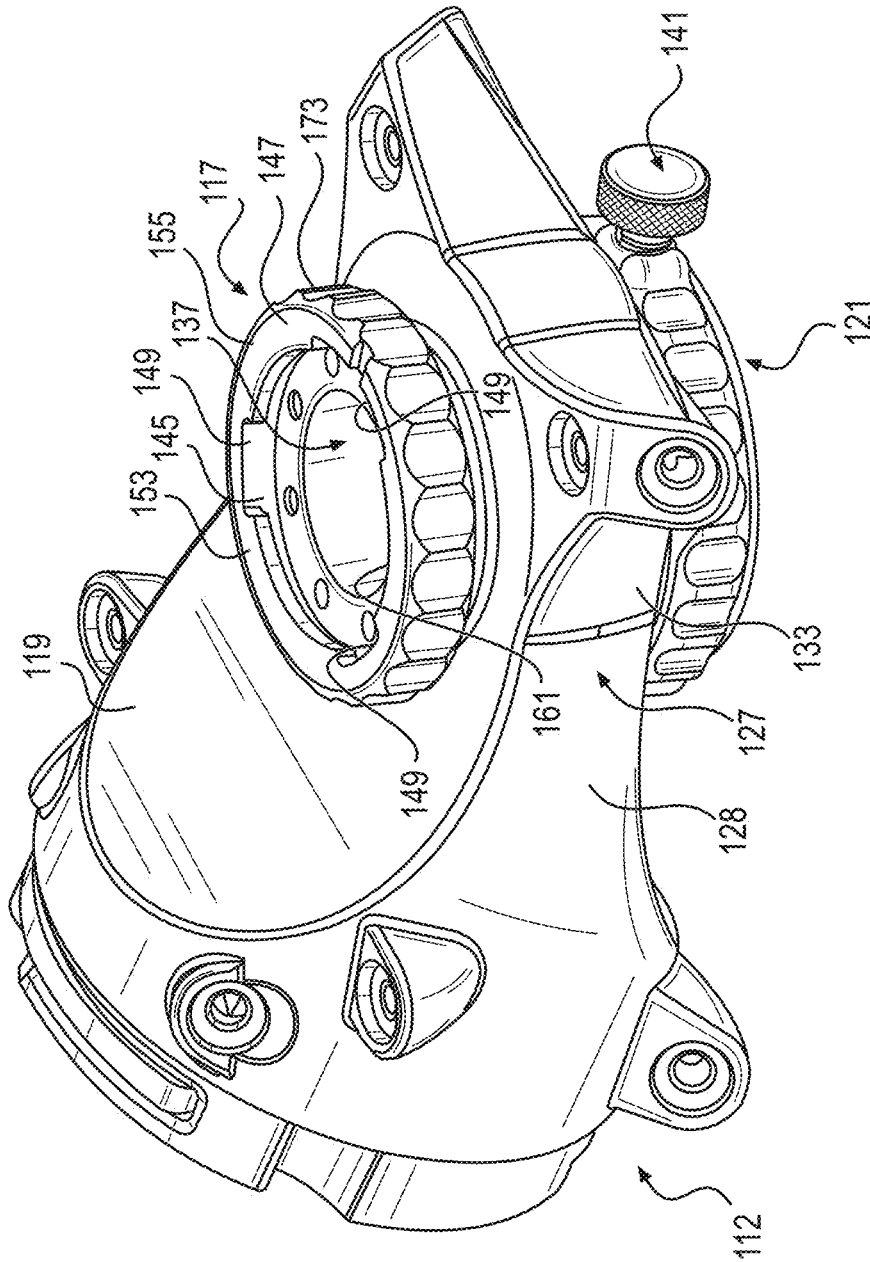


FIG. 12

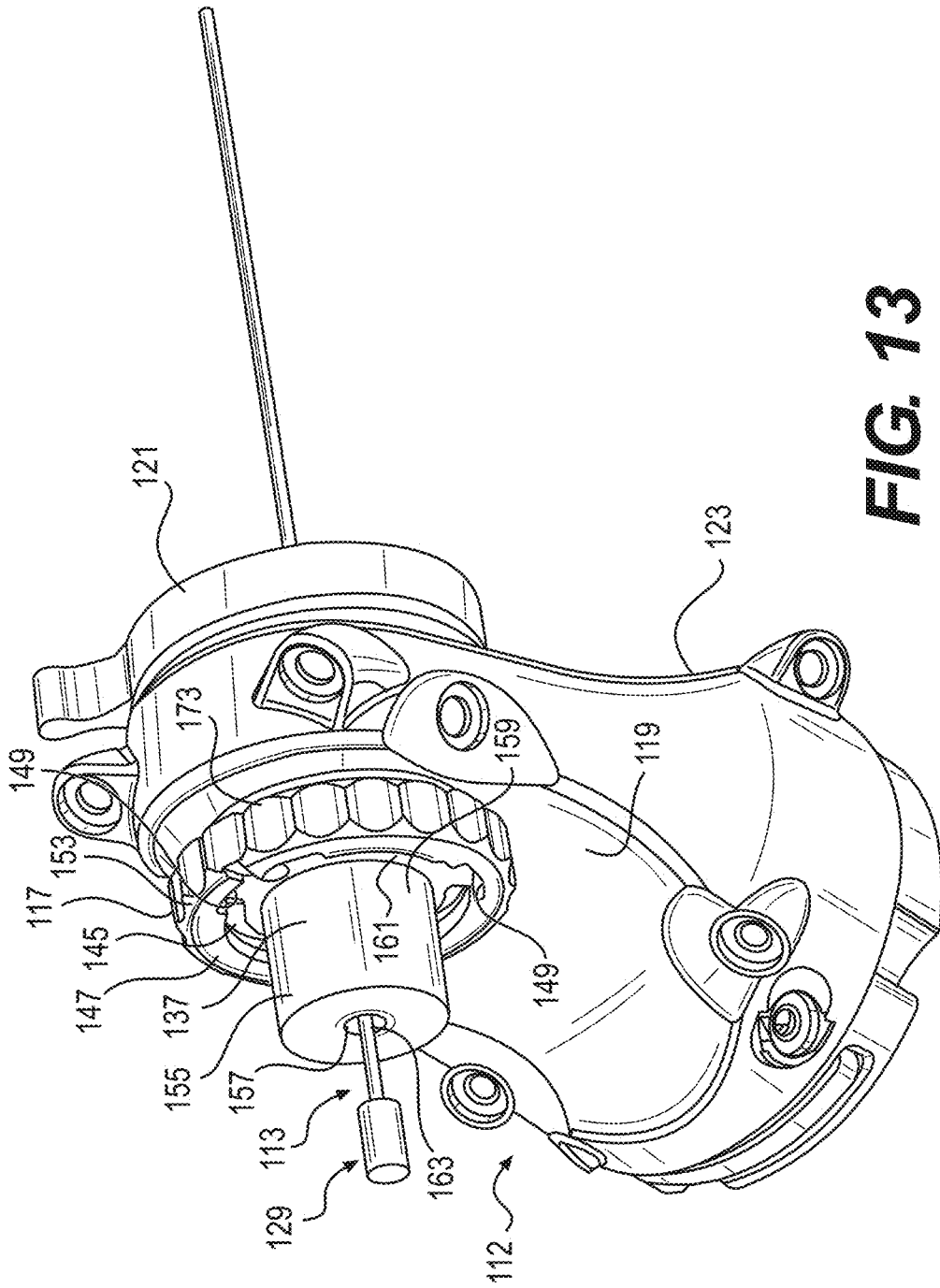


FIG. 13

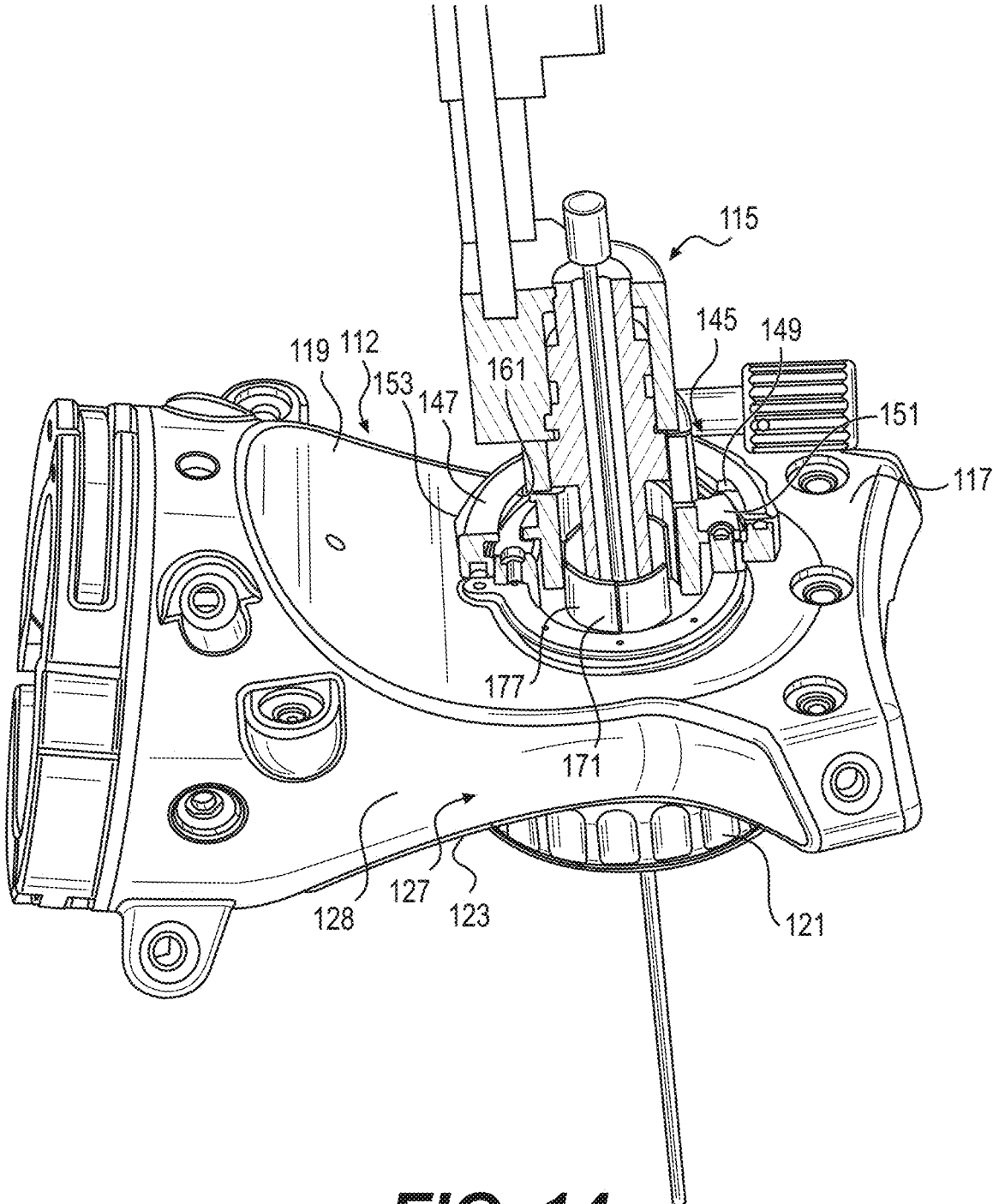


FIG. 14

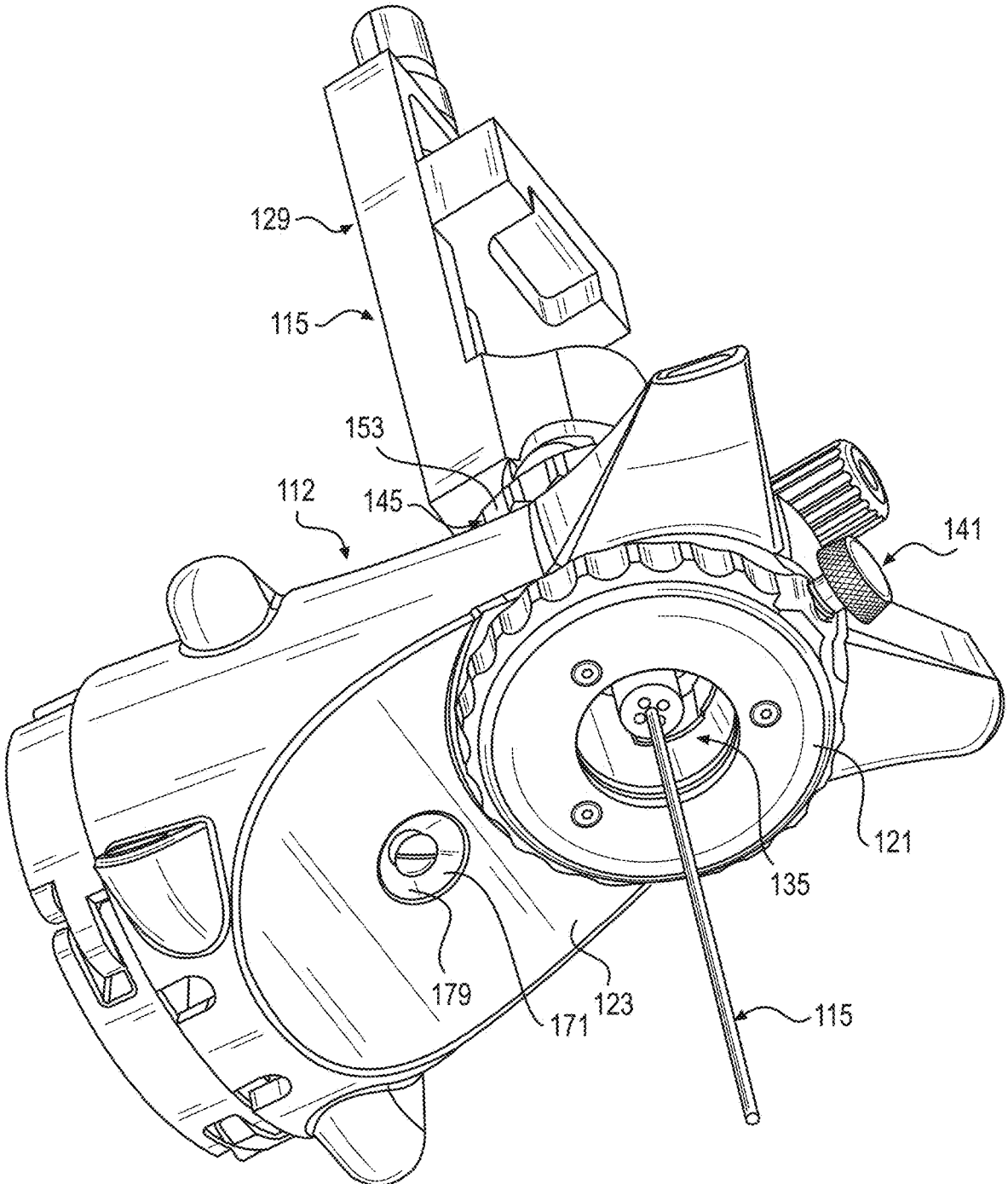


FIG. 15

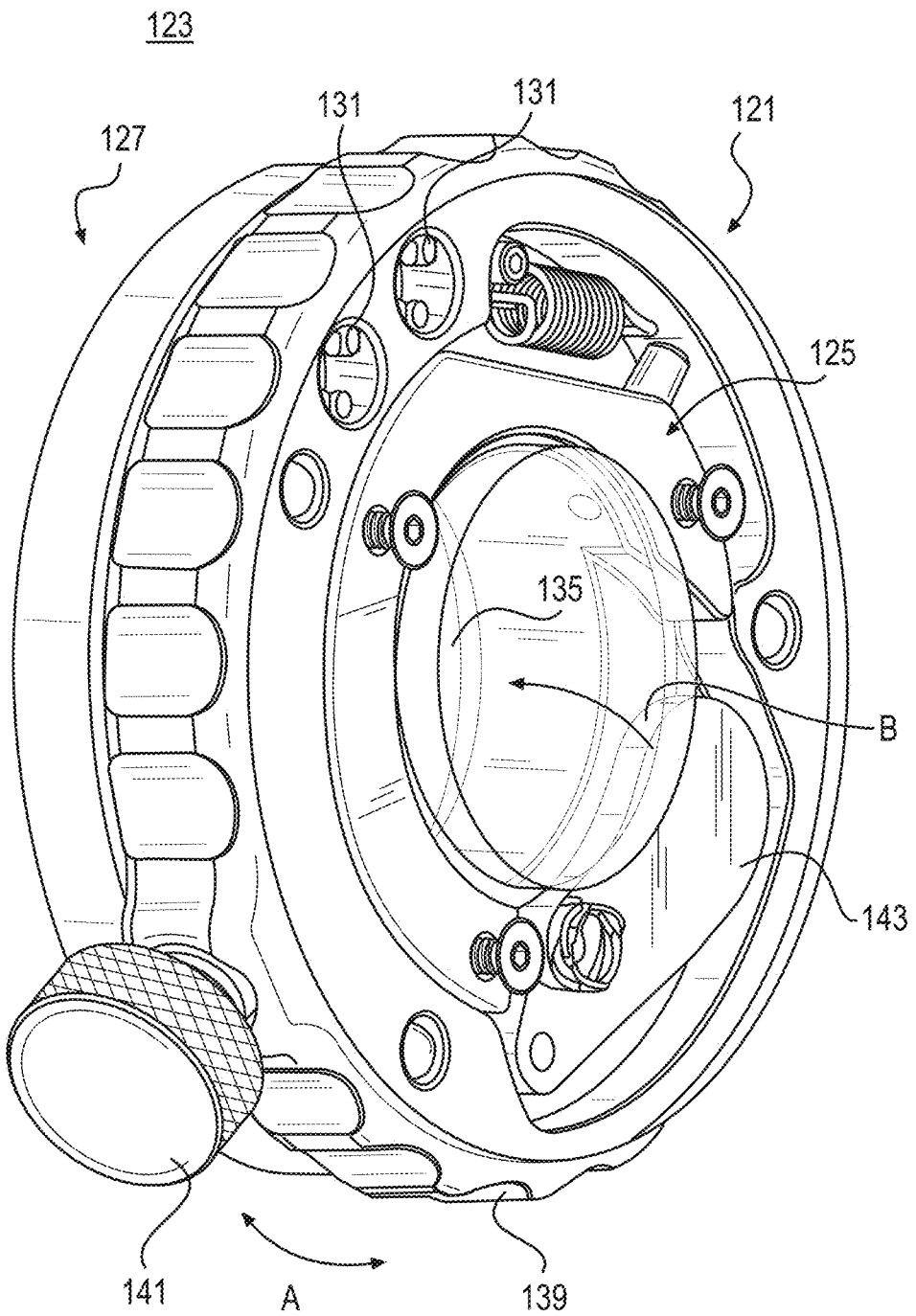


FIG. 16

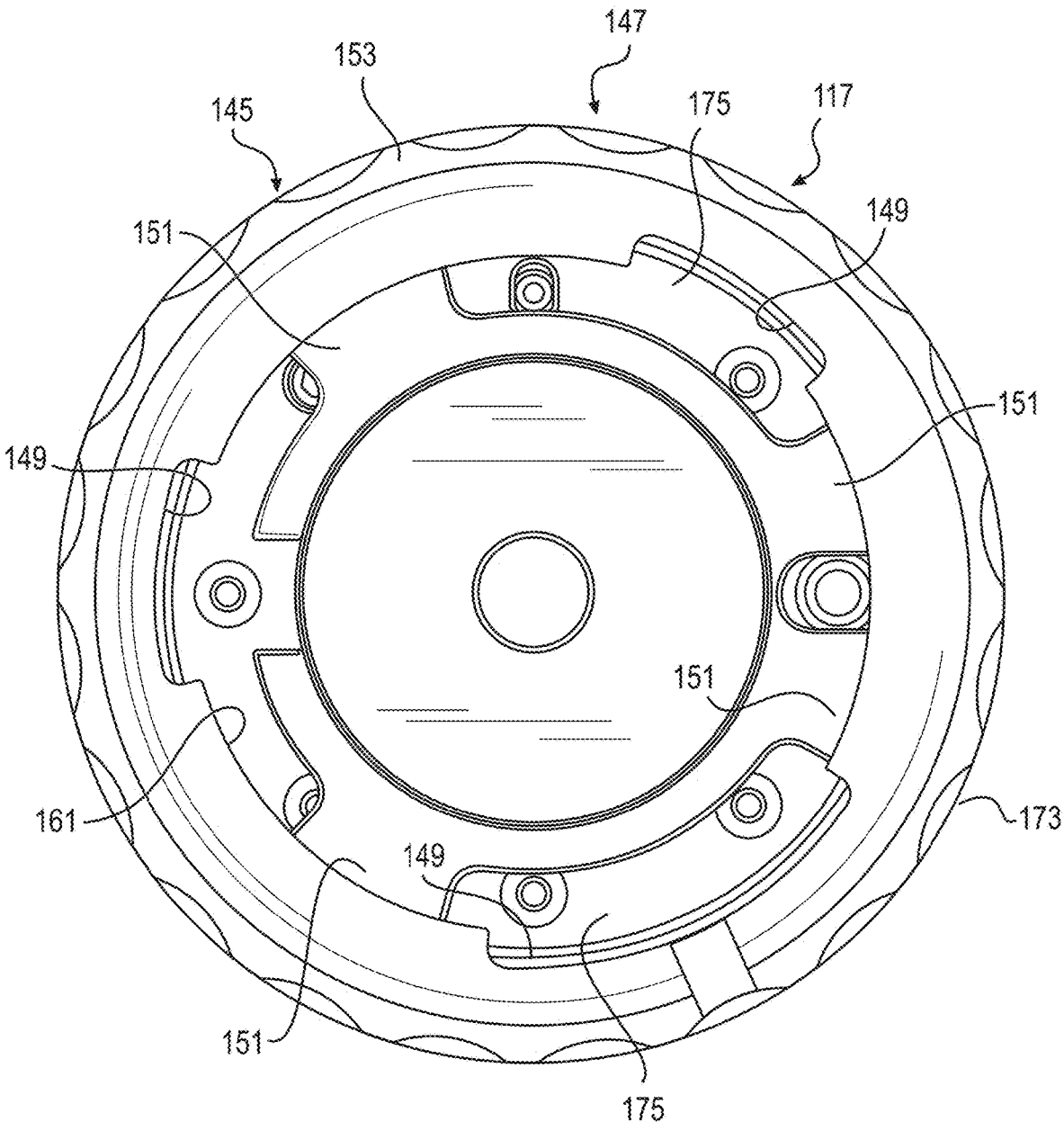


FIG. 18

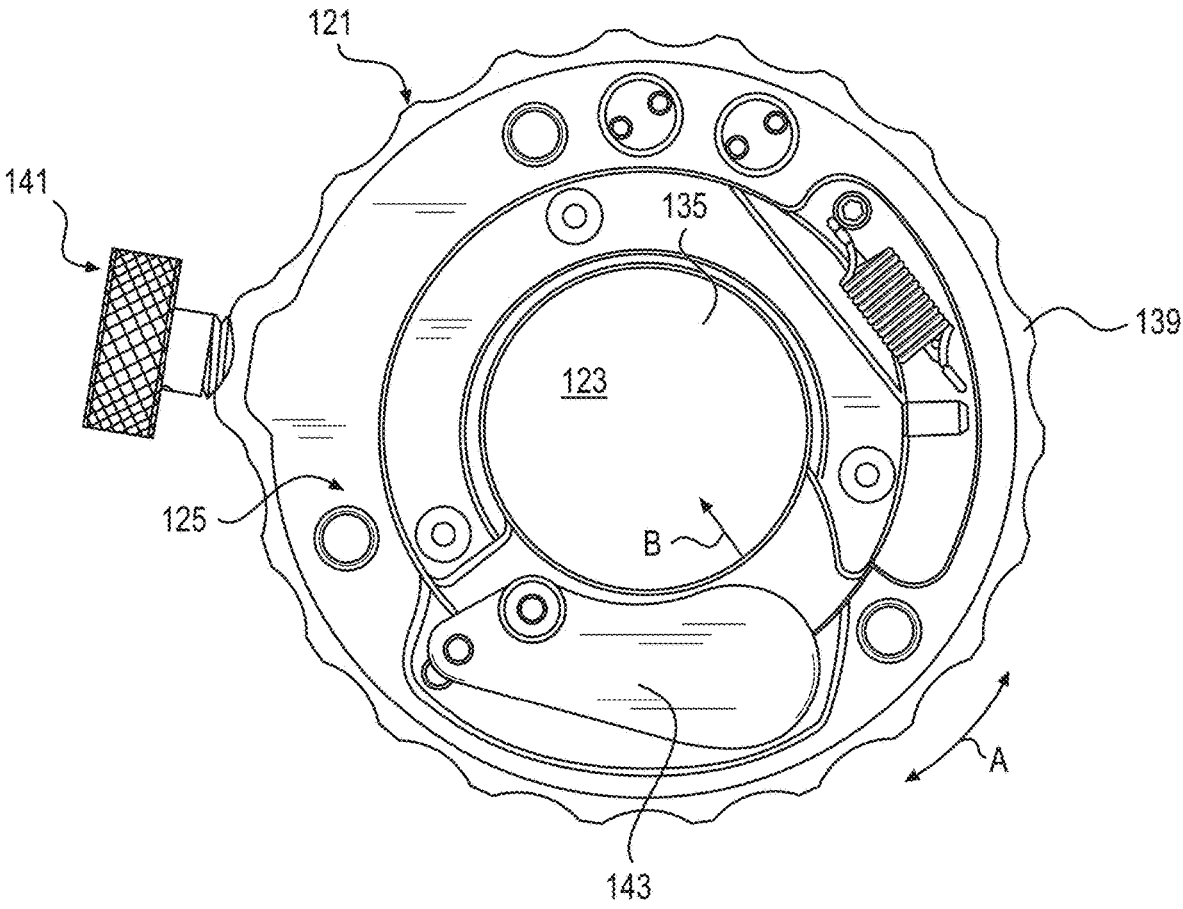


FIG. 19

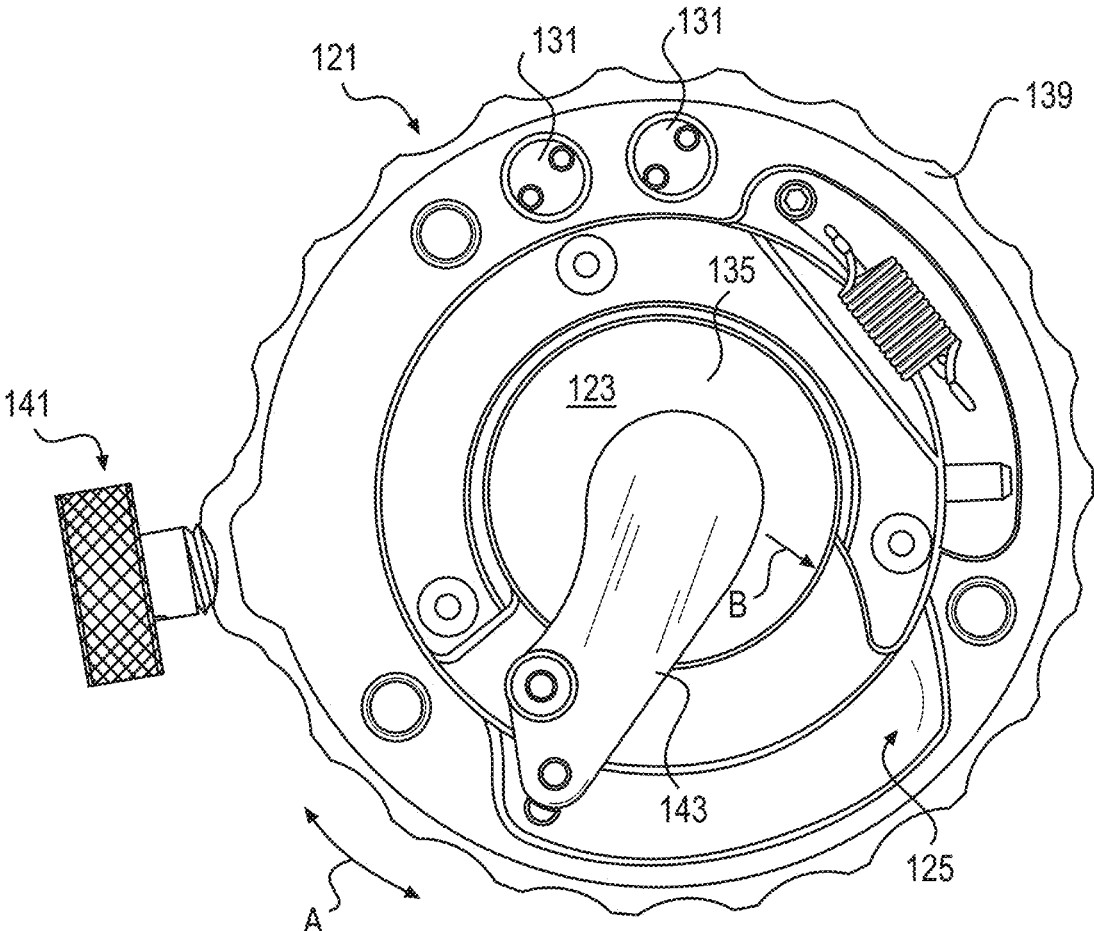


FIG. 20

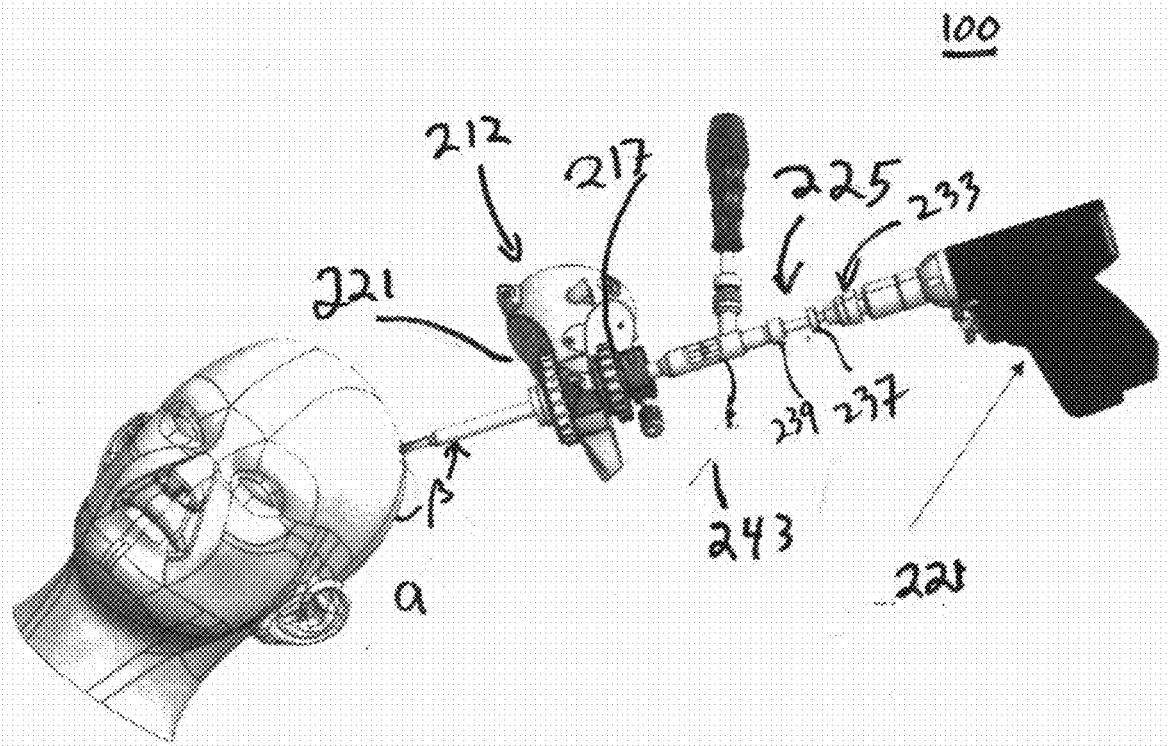


Fig 21

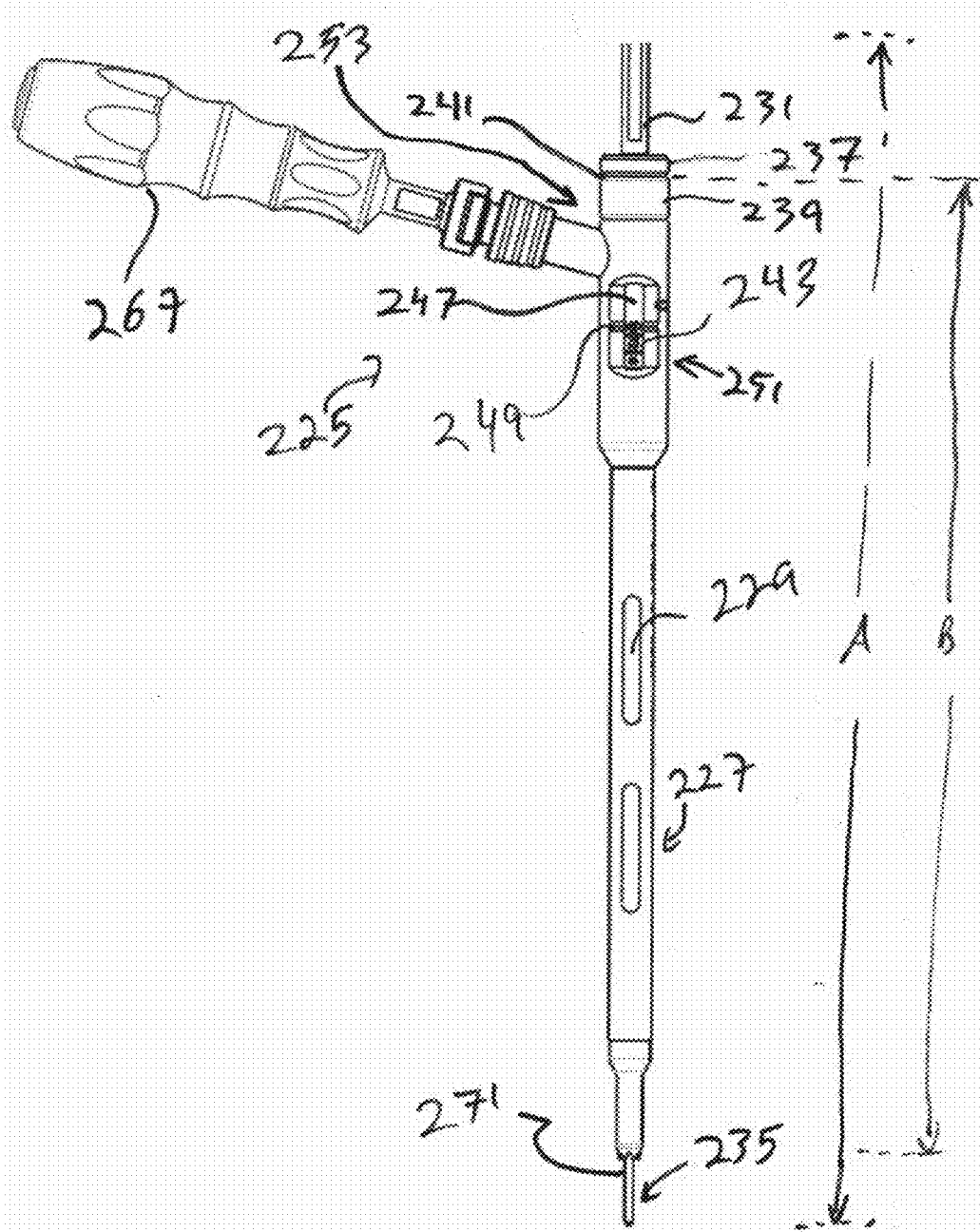


FIG 22

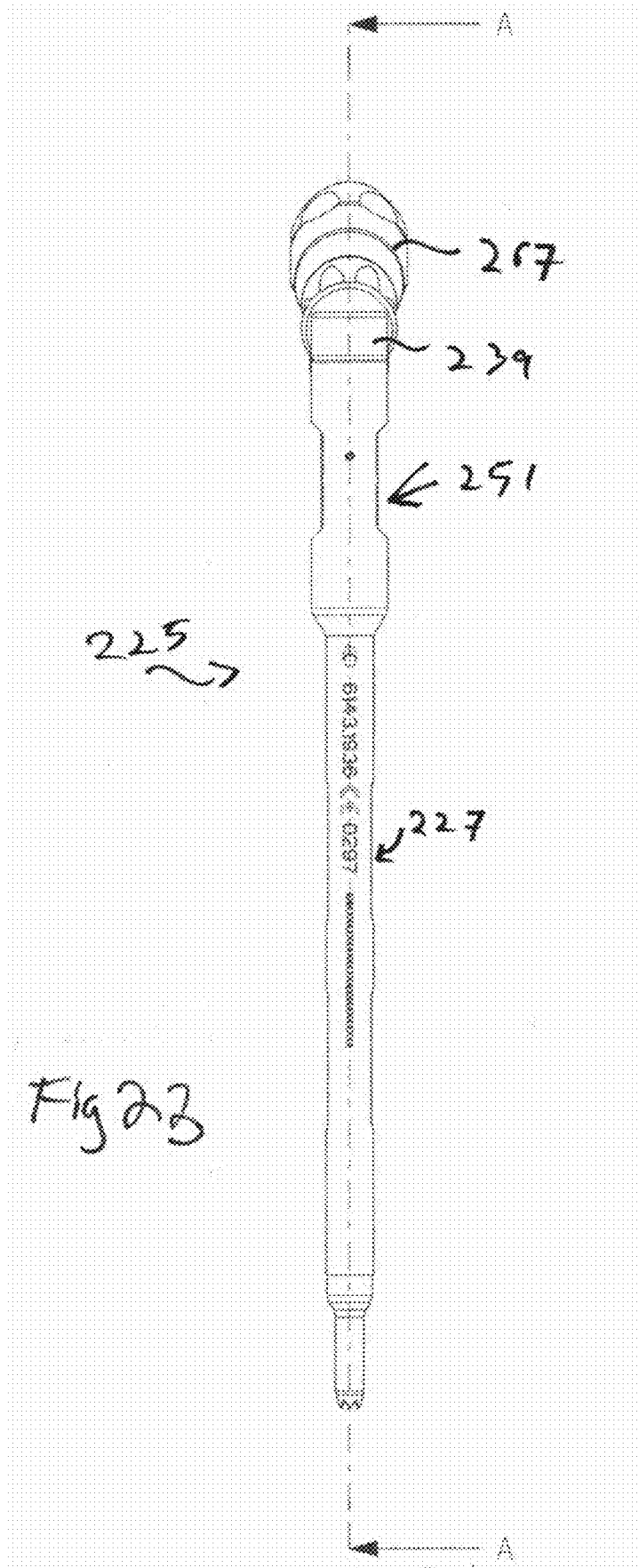


Fig 23

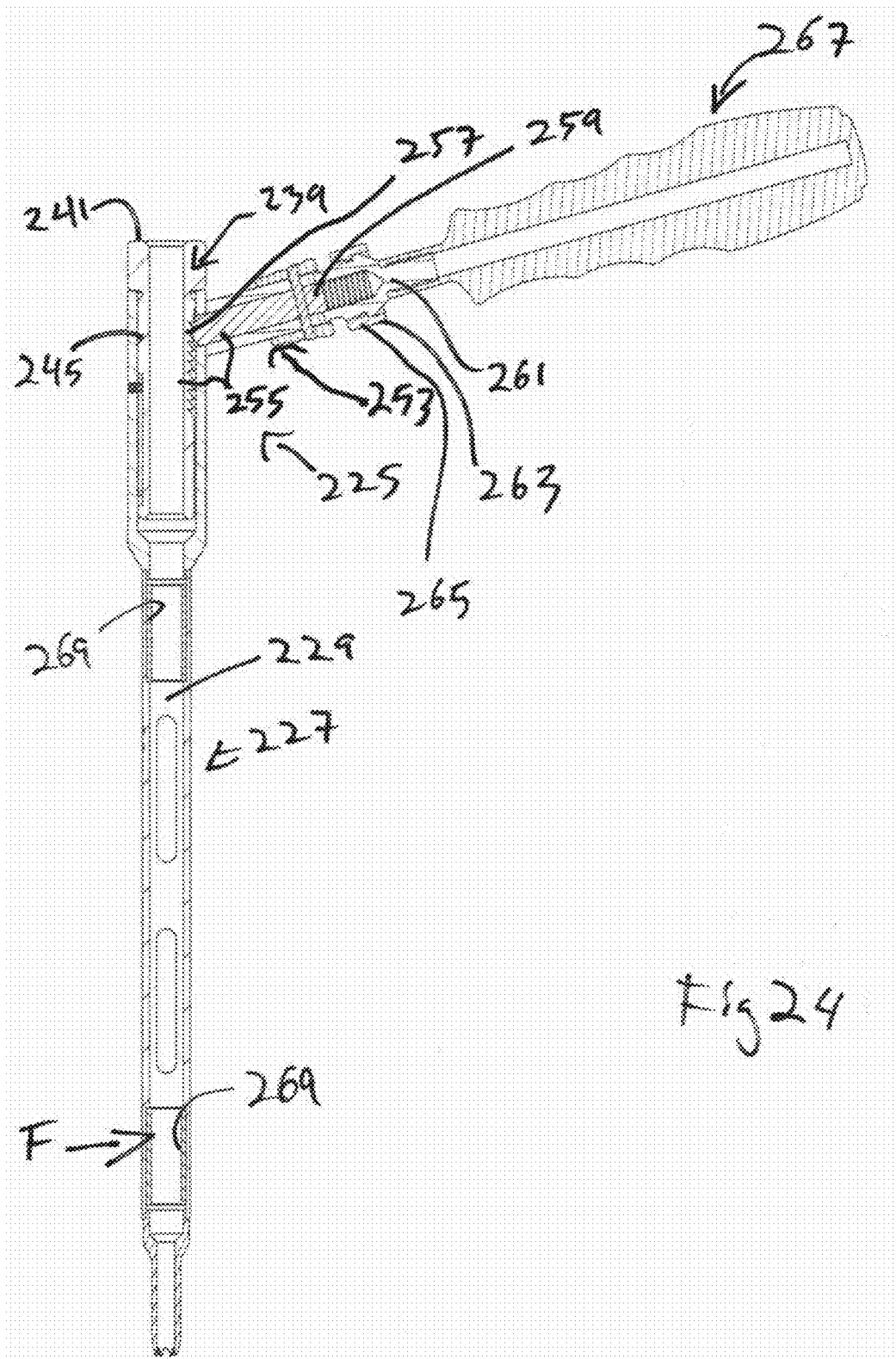


Fig 24

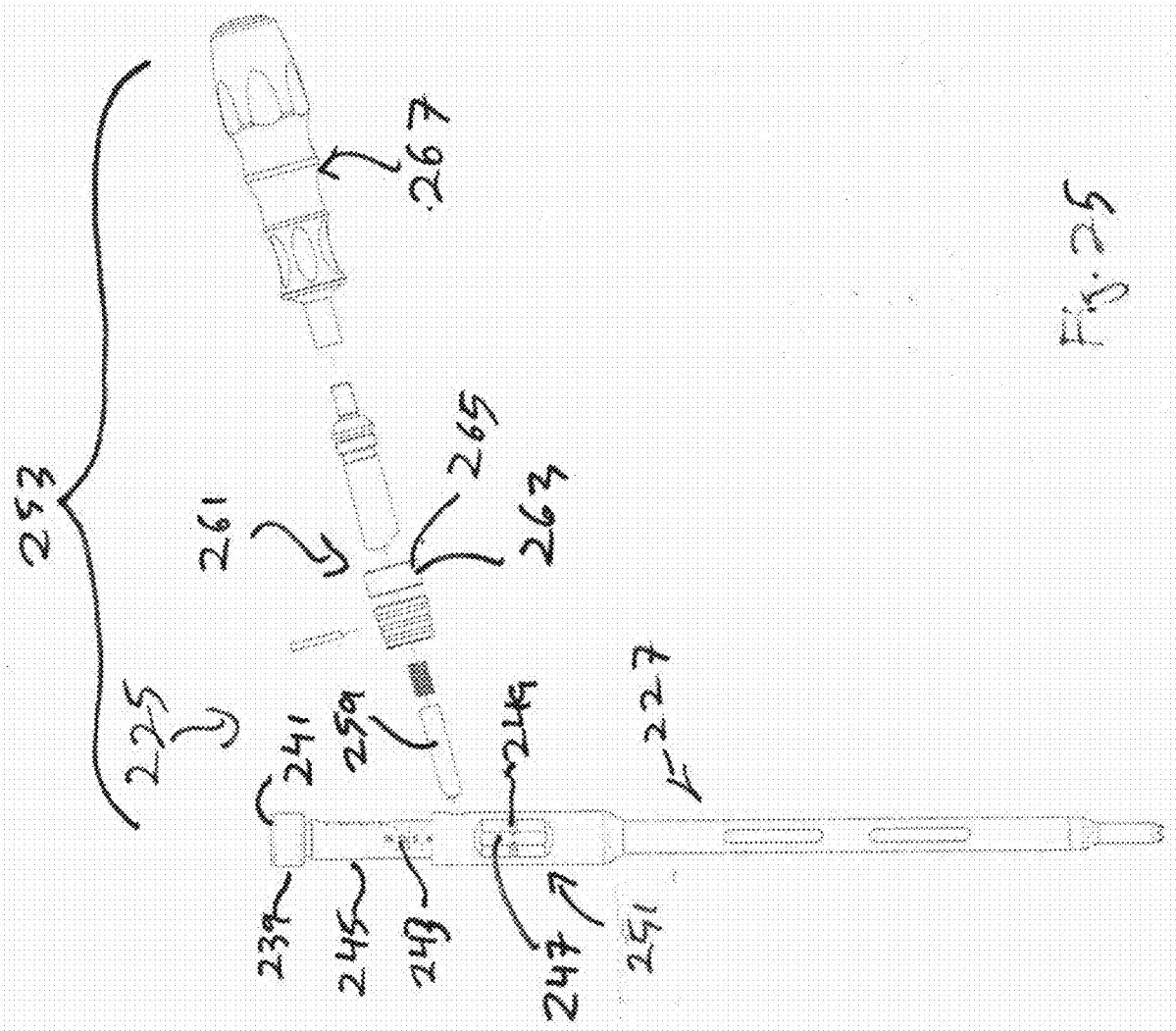


Fig. 25

**SYSTEM FOR NEURONAVIGATION
REGISTRATION AND ROBOTIC
TRAJECTORY GUIDANCE, ROBOTIC
SURGERY, AND RELATED METHODS AND
DEVICES**

CROSS-REFERENCE TO RELATED
APPLICATION

[0001] This application is a continuation-in-part of U.S. patent application Ser. No. 16/452,737, filed Jun. 26, 2019, which is a continuation-in-part of U.S. patent application Ser. No. 16/361,863, filed on Mar. 22, 2019, the entire contents of each of which are hereby incorporated herein by reference for all purposes.

FIELD

[0002] The present disclosure relates to medical devices and systems, and more particularly, systems for neuronavigation registration and robotic trajectory guidance, robotic surgery, and related methods and devices.

BACKGROUND

[0003] Position recognition systems for robot assisted surgeries are used to determine the position of and track a particular object in 3-dimensions (3D). In robot assisted surgeries, for example, certain objects, such as surgical instruments, need to be tracked with a high degree of precision as the instrument is being positioned and moved by a robot or by a physician, for example.

[0004] Position recognition systems may use passive and/or active sensors or markers for registering and tracking the positions of the objects. Using these sensors, the system may geometrically resolve the 3-dimensional position of the sensors based on information from or with respect to one or more cameras, signals, or sensors, etc. These surgical systems can therefore utilize position feedback to precisely guide movement of robotic arms and tools relative to a patients' surgical site. Thus, there is a need for a system that efficiently and accurately provide neuronavigation registration and robotic trajectory guidance in a surgical environment.

[0005] End-effectors used in robotic surgery may be limited to use in only certain procedures, or may suffer from other drawbacks or disadvantages.

SUMMARY

[0006] According to some implementations, a surgical robot system is configured for surgery on an anatomical feature of a patient, and includes a surgical robot, a robot arm connected to such surgical robot, and an end-effector connected to the robot arm. The end-effector has a surgical tool selectively connected to it, and the robot system includes a memory accessible by a suitable processor circuit which processes machine-readable instructions. Among the instructions which are executable by the system are ones which, in response to user input, determine a drill target and an associated drill trajectory. The instructions also may be executed to cause the end-effector to move to a position corresponding to such determined target and determined drill trajectory. Once positioned in this manner, the system and corresponding instructions will permit advancement of the aforementioned drill toward the determined target.

[0007] In certain implementations, the system includes a drill guide which is connectible between the end-effector and the drill. The drill guide is configured to stop advancement of the drill at a pre-selected drill depth associated with the determined target, and is further configured to guide the drill along the determined drill trajectory during advancement of the drill. As such, the drill guide provides further assurance against over-penetration or over-engagement of the anatomical feature being operated upon and likewise assists in guiding the trajectory of the drill, including when such trajectory is oblique to the anatomical feature.

[0008] The drill guide includes a guide shaft with a bore extending longitudinally therethrough and having proximal and distal openings to the bore. The guide shaft and the corresponding bore are sized to slideably receive a drill bit of the drill therethrough, such drill bit having an associated drill tip and being operatively connected to advancement and rotating mechanisms of the drill at a proximal location by a suitable chuck. The drill guide includes a depth stop which is mounted to the proximal end of the guide shaft and selectively slideable longitudinally to vary the length of the guide shaft relative to the predetermined length of the drill bit received in the drill. The drill stop has a surface located and otherwise disposed to engage the distal surface of the chuck of the drill. As such, engagement between the chuck and the depth stop limits the depth to which the drill tip is advanceable by an amount corresponding to the position of the depth stop.

[0009] In certain implementations, the drill guide makes use of a depth indicator having indicia corresponding to graduated depths of advancement of the drill bit associated with the drill guide during the operative procedures contemplated by the surgical robot system. The depth stop may be formed so as to include a longitudinal stem, this stem being slideably received within the bore of the guide shaft. The guide shaft, in turn, has a window formed therein which is sized and located to reveal the longitudinal stem of the depth stop when it is received in the guide shaft. With such an arrangement, the aforementioned indicia associated with the graduated depth may be located either on the longitudinal stem visible through the window or on portions adjacent to the window, and such indicia are movable relative to a pointer or other indicator relative to which the graduated depth scale moves. In this manner, the desired depth limit may be manually selected by visually perceiving the numerical value of the graduated depths aligned with the associated pointer or indicator.

[0010] In still other aspects of the disclosed implementations, the drill guide has an engagement mechanism to set the depth stop at one of a plurality of selectable, longitudinal positions corresponding to the desired drill depth. One suitable engagement mechanism may include a ratchet assembly engageable at one of a plurality of longitudinally spaced locations between the proximal and distal ends of the depth stop. In one suitable implementation, the ratchet assembly includes a ratchet that may be disengaged and engaged by actuation or release, respectively, of a spring-biased trigger. Such trigger may have a trigger lock operatively associated therewith so that once the ratchet of the ratchet assembly has engaged the depth stop at a selected longitudinal position, such trigger lock inhibits inadvertent actuation of the trigger which would cause disengagement of the ratchet and potential longitudinal movement of the depth stop. The drill guide may include a handle operatively

connected to the engagement mechanism so as to manually set the depth stop at the selected one of the longitudinal positions.

[0011] In still other implementations, the guide shaft has at least one bushing, and such bushing may be sized to engage the longitudinal surface at the distal end of the drill bit in such a manner so as to exert a force on such distal drill bit end to oppose lateral displacement of the drill bit within the guide shaft. Such opposing force may be sufficient to reduce deviation of the drill bit from the determined drill trajectory, especially when such trajectory is at an oblique angle to the anatomical feature being engaged.

[0012] The above-described system and its various features may be associated with a variety of related procedures or processes, collectively referred to herein as methods. One such method involves guiding a drill during robot-assisted surgery on an anatomical feature of a patient, such method including the determination by suitable computer means of a drill target and an associated drill trajectory. Thereafter, the end-effector is caused to move, such as by means of a computer, to a position corresponding to the determined target and the determined drill trajectory. At any other point prior to drill advancement during operations, the depth stop connected to the end-effector may be manually set at one of a plurality of selectable positions corresponding to a desired depth of advancement of the drill relative to the anatomical feature. In this manner, the drill is limited from penetrating the anatomical feature beyond the desired depth set manually by the depth stop.

[0013] In another possible method hereunder, the depth stop is displaced relative to visually perceptible indicia corresponding to graduated depths of advancement of the drill associated with the system. Once a suitable location of the depth stop is determined by visual perception, the depth stop may be secured at a position corresponding to one of the graduated depths indicated on the indicia. The steps of displacing and securing the depth stop may involve actuating a spring-biased trigger to disengage the depth stop from a first position, longitudinally sliding the depth stop relative to the visually perceptible indicia to a second position corresponding to the desired position of the depth stop, and then releasing the trigger to re-engage the depth stop at the desired position.

[0014] Other methods and related devices and systems, and corresponding methods and computer program products according to embodiments will be or become apparent to one with skill in the art upon review of the following drawings and detailed description. It is intended that all such devices and systems, and corresponding methods and computer program products be included within this description, be within the scope of the present disclosure, and be protected by the accompanying claims. Moreover, it is intended that all embodiments disclosed herein can be implemented separately or combined in any way and/or combination.

BRIEF DESCRIPTION OF THE DRAWINGS

[0015] The accompanying drawings, which are included to provide a further understanding of the disclosure and are incorporated in a constitute a part of this application, illustrate certain non-limiting embodiments of inventive concepts. In the drawings:

[0016] FIG. 1A is an overhead view of an arrangement for locations of a robotic system, patient, surgeon, and other medical personnel during a surgical procedure, according to some embodiments;

[0017] FIG. 1B is an overhead view of an alternate arrangement for locations of a robotic system, patient, surgeon, and other medical personnel during a cranial surgical procedure, according to some embodiments;

[0018] FIG. 2 illustrates a robotic system including positioning of the surgical robot and a camera relative to the patient according to some embodiments;

[0019] FIG. 3 is a flowchart diagram illustrating computer-implemented operations for determining a position and orientation of an anatomical feature of a patient with respect to a robot arm of a surgical robot, according to some embodiments;

[0020] FIG. 4 is a diagram illustrating processing of data for determining a position and orientation of an anatomical feature of a patient with respect to a robot arm of a surgical robot, according to some embodiments;

[0021] FIGS. 5A-5C illustrate a system for registering an anatomical feature of a patient using a computerized tomography (CT) localizer, a frame reference array (FRA), and a dynamic reference base (DRB), according to some embodiments;

[0022] FIGS. 6A and 6B illustrate a system for registering an anatomical feature of a patient using fluoroscopy (fluoro) imaging, according to some embodiments;

[0023] FIG. 7 illustrates a system for registering an anatomical feature of a patient using an intraoperative CT fixture (ICT) and a DRB, according to some embodiments;

[0024] FIGS. 8A and 8B illustrate systems for registering an anatomical feature of a patient using a DRB and an X-ray cone beam imaging device, according to some embodiments;

[0025] FIG. 9 illustrates a system for registering an anatomical feature of a patient using a navigated probe and fiducials for point-to-point mapping of the anatomical feature, according to some embodiments;

[0026] FIG. 10 illustrates a two-dimensional visualization of an adjustment range for a centerpoint-arc mechanism, according to some embodiments;

[0027] FIG. 11 illustrates a two-dimensional visualization of virtual point rotation mechanism, according to some embodiments;

[0028] FIG. 12 is an isometric view of one possible implementation of an end-effector according to the present disclosure;

[0029] FIG. 13 is an isometric view of another possible implementation of an end-effector of the present disclosure;

[0030] FIG. 14 is a partial cutaway, isometric view of still another possible implementation of an end-effector according to the present disclosure;

[0031] FIG. 15 is a bottom angle isometric view of yet another possible implementation of an end-effector according to the present disclosure;

[0032] FIG. 16 is an isometric view of one possible tool stop for use with an end-effector according to the present disclosure;

[0033] FIGS. 17 and 18 are top plan views of one possible implementation of a tool insert locking mechanism of an end-effector according to the present disclosure;

[0034] FIGS. 19 and 20 are top plan views of the tool stop of FIG. 16, showing open and closed positions, respectively;

[0035] FIG. 21 is a side, elevational view of another implementation of the robot system disclosed herein, including an end-effector and associated drill guide;

[0036] FIG. 22 is a close-up, side-elevational view of the drill guide of FIG. 21;

[0037] FIG. 23 is a front elevational view of the drill guide of FIGS. 21-22;

[0038] FIG. 24 is a cross sectional view of the drill guide of FIGS. 21-23 taken along the line of A-A of FIG. 23; and

[0039] FIG. 25 is an exploded, side-elevational view of the drill guide of FIGS. 21-24.

DETAILED DESCRIPTION

[0040] It is to be understood that the present disclosure is not limited in its application to the details of construction and the arrangement of components set forth in the description herein or illustrated in the drawings. The teachings of the present disclosure may be used and practiced in other embodiments and practiced or carried out in various ways. Also, it is to be understood that the phraseology and terminology used herein is for the purpose of description and should not be regarded as limiting. The use of “including,” “comprising,” or “having” and variations thereof herein is meant to encompass the items listed thereafter and equivalents thereof as well as additional items. Unless specified or limited otherwise, the terms “mounted,” “connected,” “supported,” and “coupled” and variations thereof are used broadly and encompass both direct and indirect mountings, connections, supports, and couplings. Further, “connected” and “coupled” are not restricted to physical or mechanical connections or couplings.

[0041] The following discussion is presented to enable a person skilled in the art to make and use embodiments of the present disclosure. Various modifications to the illustrated embodiments will be readily apparent to those skilled in the art, and the principles herein can be applied to other embodiments and applications without departing from embodiments of the present disclosure. Thus, the embodiments are not intended to be limited to embodiments shown, but are to be accorded the widest scope consistent with the principles and features disclosed herein. The following detailed description is to be read with reference to the figures, in which like elements in different figures have like reference numerals. The figures, which are not necessarily to scale, depict selected embodiments and are not intended to limit the scope of the embodiments. Skilled artisans will recognize the examples provided herein have many useful alternatives and fall within the scope of the embodiments.

[0042] According to some other embodiments, systems for neuronavigation registration and robotic trajectory guidance, and related methods and devices are disclosed. In some embodiments, a first image having an anatomical feature of a patient, a registration fixture that is fixed with respect to the anatomical feature of the patient, and a first plurality of fiducial markers that are fixed with respect to the registration fixture is analyzed, and a position is determined for each fiducial marker of the first plurality of fiducial markers. Next, based on the determined positions of the first plurality of fiducial markers, a position and orientation of the registration fixture with respect to the anatomical feature is determined. A data frame comprising a second plurality of tracking markers that are fixed with respect to the registration fixture is also analyzed, and a position is determined for each tracking marker of the second plurality of tracking

markers. Based on the determined positions of the second plurality of tracking markers, a position and orientation of the registration fixture with respect to a robot arm of a surgical robot is determined. Based on the determined position and orientation of the registration fixture with respect to the anatomical feature and the determined position and orientation of the registration fixture with respect to the robot arm, a position and orientation of the anatomical feature with respect to the robot arm is determined, which allows the robot arm to be controlled based on the determined position and orientation of the anatomical feature with respect to the robot arm.

[0043] Advantages of this and other embodiments include the ability to combine neuronavigation and robotic trajectory alignment into one system, with support for a wide variety of different registration hardware and methods. For example, as will be described in detail below, embodiments may support both computerized tomography (CT) and fluoroscopy (fluoro) registration techniques, and may utilize frame-based and/or frameless surgical arrangements. Moreover, in many embodiments, if an initial (e.g. preoperative) registration is compromised due to movement of a registration fixture, registration of the registration fixture (and of the anatomical feature by extension) can be re-established intra-operatively without suspending surgery and re-capturing preoperative images.

[0044] Referring now to the drawings, FIG. 1A illustrates a surgical robot system 100 in accordance with an embodiment. Surgical robot system 100 may include, for example, a surgical robot 102, one or more robot arms 104, a base 106, a display 110, an end-effector 112, for example, including a guide tube 114, and one or more tracking markers 118. The robot arm 104 may be movable along and/or about an axis relative to the base 106, responsive to input from a user, commands received from a processing device, or other methods. The surgical robot system 100 may include a patient tracking device 116 also including one or more tracking markers 118, which is adapted to be secured directly to the patient 210 (e.g., to a bone of the patient 210). As will be discussed in greater detail below, the tracking markers 118 may be secured to or may be part of a stereotactic frame that is fixed with respect to an anatomical feature of the patient 210. The stereotactic frame may also be secured to a fixture to prevent movement of the patient 210 during surgery.

[0045] According to an alternative embodiment, FIG. 1B is an overhead view of an alternate arrangement for locations of a robotic system 100, patient 210, surgeon 120, and other medical personnel during a cranial surgical procedure. During a cranial procedure, for example, the robot 102 may be positioned behind the head 128 of the patient 210. The robot arm 104 of the robot 102 has an end-effector 112 that may hold a surgical instrument 108 during the procedure. In this example, a stereotactic frame 134 is fixed with respect to the patient's head 128, and the patient 210 and/or stereotactic frame 134 may also be secured to a patient base 211 to prevent movement of the patient's head 128 with respect to the patient base 211. In addition, the patient 210, the stereotactic frame 134 and/or the patient base 211 may be secured to the robot base 106, such as via an auxiliary arm 107, to prevent relative movement of the patient 210 with respect to components of the robot 102 during surgery. Different devices may be positioned with respect to the patient's head 128 and/or patient base 211 as desired to

facilitate the procedure, such as an intra-operative CT device **130**, an anesthesiology station **132**, a scrub station **136**, a neuro-modulation station **138**, and/or one or more remote pendants **140** for controlling the robot **102** and/or other devices or systems during the procedure.

[0046] The surgical robot system **100** in the examples of FIGS. **1A** and/or **1B** may also use a sensor, such as a camera **200**, for example, positioned on a camera stand **202**. The camera stand **202** can have any suitable configuration to move, orient, and support the camera **200** in a desired position. The camera **200** may include any suitable camera or cameras, such as one or more cameras (e.g., bifocal or stereophotogrammetric cameras), able to identify, for example, active or passive tracking markers **118** (shown as part of patient tracking device **116** in FIG. **2**) in a given measurement volume viewable from the perspective of the camera **200**. In this example, the camera **200** may scan the given measurement volume and detect the light that comes from the tracking markers **118** in order to identify and determine the position of the tracking markers **118** in three-dimensions. For example, active tracking markers **118** may include infrared-emitting markers that are activated by an electrical signal (e.g., infrared light emitting diodes (LEDs)), and/or passive tracking markers **118** may include retro-reflective markers that reflect infrared or other light (e.g., they reflect incoming IR radiation into the direction of the incoming light), for example, emitted by illuminators on the camera **200** or other suitable sensor or other device.

[0047] In many surgical procedures, one or more targets of surgical interest, such as targets within the brain for example, are localized to an external reference frame. For example, stereotactic neurosurgery may use an externally mounted stereotactic frame that facilitates patient localization and implant insertion via a frame mounted arc. Neuro-navigation is used to register, e.g., map, targets within the brain based on pre-operative or intraoperative imaging. Using this pre-operative or intraoperative imaging, links and associations can be made between the imaging and the actual anatomical structures in a surgical environment, and these links and associations can be utilized by robotic trajectory systems during surgery.

[0048] According to some embodiments, various software and hardware elements may be combined to create a system that can be used to plan, register, place and verify the location of an instrument or implant in the brain. These systems may integrate a surgical robot, such as the surgical robot **102** of FIGS. **1A** and/or **1B**, and may employ a surgical navigation system and planning software to program and control the surgical robot. In addition or alternatively, the surgical robot **102** may be remotely controlled, such as by nonsterile personnel.

[0049] The robot **102** may be positioned near or next to patient **210**, and it will be appreciated that the robot **102** can be positioned at any suitable location near the patient **210** depending on the area of the patient **210** undergoing the operation. The camera **200** may be separated from the surgical robot system **100** and positioned near or next to patient **210** as well, in any suitable position that allows the camera **200** to have a direct visual line of sight to the surgical field **208**. In the configuration shown, the surgeon **120** may be positioned across from the robot **102**, but is still able to manipulate the end-effector **112** and the display **110**. A surgical assistant **126** may be positioned across from the surgeon **120** again with access to both the end-effector **112**

and the display **110**. If desired, the locations of the surgeon **120** and the assistant **126** may be reversed. The traditional areas for the anesthesiologist **122** and the nurse or scrub tech **124** may remain unimpeded by the locations of the robot **102** and camera **200**.

[0050] With respect to the other components of the robot **102**, the display **110** can be attached to the surgical robot **102** and in other embodiments, the display **110** can be detached from surgical robot **102**, either within a surgical room with the surgical robot **102**, or in a remote location. The end-effector **112** may be coupled to the robot arm **104** and controlled by at least one motor. In some embodiments, end-effector **112** can comprise a guide tube **114**, which is able to receive and orient a surgical instrument **108** used to perform surgery on the patient **210**. As used herein, the term “end-effector” is used interchangeably with the terms “end-effectuator” and “effectuator element.” Although generally shown with a guide tube **114**, it will be appreciated that the end-effector **112** may be replaced with any suitable instrumentation suitable for use in surgery. In some embodiments, end-effector **112** can comprise any known structure for effecting the movement of the surgical instrument **108** in a desired manner.

[0051] The surgical robot **102** is able to control the translation and orientation of the end-effector **112**. The robot **102** is able to move end-effector **112** along x-, y-, and z-axes, for example. The end-effector **112** can be configured for selective rotation about one or more of the x-, y-, and z-axis such that one or more of the Euler Angles (e.g., roll, pitch, and/or yaw) associated with end-effector **112** can be selectively controlled. In some embodiments, selective control of the translation and orientation of end-effector **112** can permit performance of medical procedures with significantly improved accuracy compared to conventional robots that use, for example, a six degree of freedom robot arm comprising only rotational axes. For example, the surgical robot system **100** may be used to operate on patient **210**, and robot arm **104** can be positioned above the body of patient **210**, with end-effector **112** selectively angled relative to the z-axis toward the body of patient **210**.

[0052] In some embodiments, the position of the surgical instrument **108** can be dynamically updated so that surgical robot **102** can be aware of the location of the surgical instrument **108** at all times during the procedure. Consequently, in some embodiments, surgical robot **102** can move the surgical instrument **108** to the desired position quickly without any further assistance from a physician (unless the physician so desires). In some further embodiments, surgical robot **102** can be configured to correct the path of the surgical instrument **108** if the surgical instrument **108** strays from the selected, preplanned trajectory. In some embodiments, surgical robot **102** can be configured to permit stoppage, modification, and/or manual control of the movement of end-effector **112** and/or the surgical instrument **108**. Thus, in use, in some embodiments, a physician or other user can operate the system **100**, and has the option to stop, modify, or manually control the autonomous movement of end-effector **112** and/or the surgical instrument **108**. Further details of surgical robot system **100** including the control and movement of a surgical instrument **108** by surgical robot **102** can be found in co-pending U.S. Patent Publication No. 2013/0345718, which is incorporated herein by reference in its entirety.

[0053] As will be described in greater detail below, the surgical robot system 100 can comprise one or more tracking markers configured to track the movement of robot arm 104, end-effector 112, patient 210, and/or the surgical instrument 108 in three dimensions. In some embodiments, a plurality of tracking markers can be mounted (or otherwise secured) thereon to an outer surface of the robot 102, such as, for example and without limitation, on base 106 of robot 102, on robot arm 104, and/or on the end-effector 112. In some embodiments, such as the embodiment of FIG. 3 below, for example, one or more tracking markers can be mounted or otherwise secured to the end-effector 112. One or more tracking markers can further be mounted (or otherwise secured) to the patient 210. In some embodiments, the plurality of tracking markers can be positioned on the patient 210 spaced apart from the surgical field 208 to reduce the likelihood of being obscured by the surgeon, surgical tools, or other parts of the robot 102. Further, one or more tracking markers can be further mounted (or otherwise secured) to the surgical instruments 108 (e.g., a screw driver, dilator, implant inserter, or the like). Thus, the tracking markers enable each of the marked objects (e.g., the end-effector 112, the patient 210, and the surgical instruments 108) to be tracked by the surgical robot system 100. In some embodiments, system 100 can use tracking information collected from each of the marked objects to calculate the orientation and location, for example, of the end-effector 112, the surgical instrument 108 (e.g., positioned in the tube 114 of the end-effector 112), and the relative position of the patient 210. Further details of surgical robot system 100 including the control, movement and tracking of surgical robot 102 and of a surgical instrument 108 can be found in U.S. Patent Publication No. 2016/0242849, which is incorporated herein by reference in its entirety.

[0054] In some embodiments, pre-operative imaging may be used to identify the anatomy to be targeted in the procedure. If desired by the surgeon the planning package will allow for the definition of a reformatted coordinate system. This reformatted coordinate system will have coordinate axes anchored to specific anatomical landmarks, such as the anterior commissure (AC) and posterior commissure (PC) for neurosurgery procedures. In some embodiments, multiple pre-operative exam images (e.g., CT or magnetic resonance (MR) images) may be co-registered such that it is possible to transform coordinates of any given point on the anatomy to the corresponding point on all other pre-operative exam images.

[0055] As used herein, registration is the process of determining the coordinate transformations from one coordinate system to another. For example, in the co-registration of preoperative images, co-registering a CT scan to an MR scan means that it is possible to transform the coordinates of an anatomical point from the CT scan to the corresponding anatomical location in the MR scan. It may also be advantageous to register at least one exam image coordinate system to the coordinate system of a common registration fixture, such as a dynamic reference base (DRB), which may allow the camera 200 to keep track of the position of the patient in the camera space in real-time so that any intraoperative movement of an anatomical point on the patient in the room can be detected by the robot system 100 and accounted for by compensatory movement of the surgical robot 102.

[0056] FIG. 3 is a flowchart diagram illustrating computer-implemented operations 300 for determining a position and orientation of an anatomical feature of a patient with respect to a robot arm of a surgical robot, according to some embodiments. The operations 300 may include receiving a first image volume, such as a CT scan, from a preoperative image capture device at a first time (Block 302). The first image volume includes an anatomical feature of a patient and at least a portion of a registration fixture that is fixed with respect to the anatomical feature of the patient. The registration fixture includes a first plurality of fiducial markers that are fixed with respect to the registration fixture. The operations 300 further include determining, for each fiducial marker of the first plurality of fiducial markers, a position of the fiducial marker relative to the first image volume (Block 304). The operations 300 further include, determining, based on the determined positions of the first plurality of fiducial markers, positions of an array of tracking markers on the registration fixture (fiducial registration array or FRA) with respect to the anatomical feature (Block 306).

[0057] The operations 300 may further include receiving a tracking data frame from an intraoperative tracking device comprising a plurality of tracking cameras at a second time that is later than the first time (Block 308). The tracking frame includes positions of a plurality of tracking markers that are fixed with respect to the registration fixture (FRA) and a plurality of tracking markers that are fixed with respect to the robot. The operations 300 further include determining, for based on the positions of tracking markers of the registration fixture, a position and orientation of the anatomical feature with respect to the tracking cameras (Block 310). The operations 300 further include determining, based on the determined positions of the plurality of tracking markers on the robot, a position and orientation of the robot arm of a surgical robot with respect to the tracking cameras (Block 312).

[0058] The operations 300 further include determining, based on the determined position and orientation of the anatomical feature with respect to the tracking cameras and the determined position and orientation of the robot arm with respect to the tracking cameras, a position and orientation of the anatomical feature with respect to the robot arm (Block 314). The operations 300 further include controlling movement of the robot arm with respect to the anatomical feature, e.g., along and/or rotationally about one or more defined axis, based on the determined position and orientation of the anatomical feature with respect to the robot arm (Block 316).

[0059] FIG. 4 is a diagram illustrating a data flow 400 for a multiple coordinate transformation system, to enable determining a position and orientation of an anatomical feature of a patient with respect to a robot arm of a surgical robot, according to some embodiments. In this example, data from a plurality of exam image spaces 402, based on a plurality of exam images, may be transformed and combined into a common exam image space 404. The data from the common exam image space 404 and data from a verification image space 406, based on a verification image, may be transformed and combined into a registration image space 408. Data from the registration image space 408 may be transformed into patient fiducial coordinates 410, which is transformed into coordinates for a DRB 412. A tracking camera 414 may detect movement of the DRB 412 (repre-

sented by DRB 412') and may also detect a location of a probe tracker 416 to track coordinates of the DRB 412 over time. A robotic arm tracker 418 determines coordinates for the robot arm based on transformation data from a Robotics Planning System (RPS) space 420 or similar modeling system, and/or transformation data from the tracking camera 414.

[0060] It should be understood that these and other features may be used and combined in different ways to achieve registration of image space, i.e., coordinates from image volume, into tracking space, i.e., coordinates for use by the surgical robot in real-time. As will be discussed in detail below, these features may include fiducial-based registration such as stereotactic frames with CT localizer, preoperative CT or MRI registered using intraoperative fluoroscopy, calibrated scanner registration where any acquired scan's coordinates are pre-calibrated relative to the tracking space, and/or surface registration using a tracked probe, for example.

[0061] In one example, FIGS. 5A-5C illustrate a system 500 for registering an anatomical feature of a patient. In this example, the stereotactic frame base 530 is fixed to an anatomical feature 528 of patient, e.g., the patient's head. As shown by FIG. 5A, the stereotactic frame base 530 may be affixed to the patient's head 528 prior to registration using pins clamping the skull or other method. The stereotactic frame base 530 may act as both a fixation platform, for holding the patient's head 528 in a fixed position, and registration and tracking platform, for alternately holding the CT localizer 536 or the FRA fixture 534. The CT localizer 536 includes a plurality of fiducial markers 532 (e.g., N-pattern radio-opaque rods or other fiducials), which are automatically detected in the image space using image processing. Due to the precise attachment mechanism of the CT localizer 536 to the base 530, these fiducial markers 532 are in known space relative to the stereotactic frame base 530. A 3D CT scan of the patient with CT localizer 536 attached is taken, with an image volume that includes both the patient's head 528 and the fiducial markers 532 of the CT localizer 536. This registration image can be taken intraoperatively or preoperatively, either in the operating room or in radiology, for example. The captured 3D image dataset is stored to computer memory.

[0062] As shown by FIG. 5B, after the registration image is captured, the CT localizer 536 is removed from the stereotactic frame base 530 and the frame reference array fixture 534 is attached to the stereotactic frame base 530. The stereotactic frame base 530 remains fixed to the patient's head 528, however, and is used to secure the patient during surgery, and serves as the attachment point of a frame reference array fixture 534. The frame reference array fixture 534 includes a frame reference array (FRA), which is a rigid array of three or more tracked markers 539, which may be the primary reference for optical tracking. By positioning the tracked markers 539 of the FRA in a fixed, known location and orientation relative to the stereotactic frame base 530, the position and orientation of the patient's head 528 may be tracked in real time. Mount points on the FRA fixture 534 and stereotactic frame base 530 may be designed such that the FRA fixture 534 attaches reproducibly to the stereotactic frame base 530 with minimal (i.e., submillimetric) variability. These mount points on the stereotactic frame base 530 can be the same mount points used by the CT localizer 536, which is removed after the scan has been

taken. An auxiliary arm (such as auxiliary arm 107 of FIG. 1B, for example) or other attachment mechanism can also be used to securely affix the patient to the robot base to ensure that the robot base is not allowed to move relative to the patient.

[0063] As shown by FIG. 5C, a dynamic reference base (DRB) 540 may also be attached to the stereotactic frame base 530. The DRB 540 in this example includes a rigid array of three or more tracked markers 542. In this example, the DRB 540 and/or other tracked markers may be attached to the stereotactic frame base 530 and/or directly to the patient's head 528 using auxiliary mounting arms 541, pins, or other attachment mechanisms. Unlike the FRA fixture 534, which mounts in only one way for unambiguous localization of the stereotactic frame base 530, the DRB 540 in general may be attached as needed for allowing unimpeded surgical and equipment access. Once the DRB 540 and FRA fixture 534 are attached, registration, which was initially related to the tracking markers 539 of the FRA, can be optionally transferred or related to the tracking markers 542 of the DRB 540. For example, if any part of the FRA fixture 534 blocks surgical access, the surgeon may remove the FRA fixture 534 and navigate using only the DRB 540. However, if the FRA fixture 534 is not in the way of the surgery, the surgeon could opt to navigate from the FRA markers 539, without using a DRB 540, or may navigate using both the FRA markers 539 and the DRB 540. In this example, the FRA fixture 534 and/or DRB 540 uses optical markers, the tracked positions of which are in known locations relative to the stereotactic frame base 530, similar to the CT localizer 536, but it should be understood that many other additional and/or alternative techniques may be used.

[0064] FIGS. 6A and 6B illustrate a system 600 for registering an anatomical feature of a patient using fluoroscopy (fluoro) imaging, according to some embodiments. In this embodiment, image space is registered to tracking space using multiple intraoperative fluoroscopy (fluoro) images taken using a tracked registration fixture 644. The anatomical feature of the patient (e.g., the patient's head 628) is positioned and rigidly affixed in a clamping apparatus 643 in a static position for the remainder of the procedure. The clamping apparatus 643 for rigid patient fixation can be a three-pin fixation system such as a Mayfield clamp, a stereotactic frame base attached to the surgical table, or another fixation method, as desired. The clamping apparatus 643 may also function as a support structure for a patient tracking array or DRB 640 as well. The DRB may be attached to the clamping apparatus using auxiliary mounting arms 641 or other means.

[0065] Once the patient is positioned, the fluoro fixture 644 is attached the fluoro unit's x-ray collecting image intensifier (not shown) and secured by tightening clamping feet 632. The fluoro fixture 644 contains fiducial markers (e.g., metal spheres laid out across two planes in this example, not shown) that are visible on 2D fluoro images captured by the fluoro image capture device and can be used to calculate the location of the x-ray source relative to the image intensifier, which is typically about 1 meter away contralateral to the patient, using a standard pinhole camera model. Detection of the metal spheres in the fluoro image captured by the fluoro image capture device also enables the software to de-warp the fluoro image (i.e., to remove pin-cushion and s-distortion). Additionally, the fluoro fixture 644

contains 3 or more tracking markers 646 for determining the location and orientation of the fluoro fixture 644 in tracking space. In some embodiments, software can project vectors through a CT image volume, based on a previously captured CT image, to generate synthetic images based on contrast levels in the CT image that appear similar to the actual fluoro images (i.e., digitally reconstructed radiographs (DRRs)). By iterating through theoretical positions of the fluoro beam until the DRRs match the actual fluoro shots, a match can be found between fluoro image and DRR in two or more perspectives, and based on this match, the location of the patient's head 628 relative to the x-ray source and detector is calculated. Because the tracking markers 646 on the fluoro fixture 644 track the position of the image intensifier and the position of the x-ray source relative to the image intensifier is calculated from metal fiducials on the fluoro fixture 644 projected on 2D images, the position of the x-ray source and detector in tracking space are known and the system is able to achieve image-to-tracking registration.

[0066] As shown by FIGS. 6A and 6B, two or more shots are taken of the head 628 of the patient by the fluoro image capture device from two different perspectives while tracking the array markers 642 of the DRB 640, which is fixed to the registration fixture 630 via a mounting arm 641, and tracking markers 646 on the fluoro fixture 644. Based on the tracking data and fluoro data, an algorithm computes the location of the head 628 or other anatomical feature relative to the tracking space for the procedure. Through image-to-tracking registration, the location of any tracked tool in the image volume space can be calculated.

[0067] For example, in one embodiment, a first fluoro image taken from a first fluoro perspective can be compared to a first DRR constructed from a first perspective through a CT image volume, and a second fluoro image taken from a second fluoro perspective can be compared to a second DRR constructed from a second perspective through the same CT image volume. Based on the comparisons, it may be determined that the first DRR is substantially equivalent to the first fluoro image with respect to the projected view of the anatomical feature, and that the second DRR is substantially equivalent to the second fluoro image with respect to the projected view of the anatomical feature. Equivalency confirms that the position and orientation of the x-ray path from emitter to collector on the actual fluoro machine as tracked in camera space matches the position and orientation of the x-ray path from emitter to collector as specified when generating the DRRs in CT space, and therefore registration of tracking space to CT space is achieved.

[0068] FIG. 7 illustrates a system 700 for registering an anatomical feature of a patient using an intraoperative CT fixture (ICT) and a DRB, according to some embodiments. As shown in FIG. 7, in one application, a fiducial-based image-to-tracking registration can be utilized that uses an intraoperative CT fixture (ICT) 750 having a plurality of tracking markers 751 and radio-opaque fiducial reference markers 732 to register the CT space to the tracking space. After stabilizing the anatomical feature 728 (e.g., the patient's head) using clamping apparatus 730 such as a three-pin Mayfield frame and/or stereotactic frame, the surgeon will affix the ICT 750 to the anatomical feature 728, DRB 740, or clamping apparatus 730, so that it is in a static position relative to the tracking markers 742 of the DRB 740, which may be held in place by mounting arm 741 or other rigid means. A CT scan is captured that encompasses

the fiducial reference markers 732 of the ICT 750 while also capturing relevant anatomy of the anatomical feature 728. Once the CT scan is loaded in the software, the system auto-identifies (through image processing) locations of the fiducial reference markers 732 of the ICT within the CT volume, which are in a fixed position relative to the tracking markers of the ICT 750, providing image-to-tracking registration. This registration, which was initially based on the tracking markers 751 of the ICT 750, is then related to or transferred to the tracking markers 742 of the DRB 740, and the ICT 750 may then be removed.

[0069] FIG. 8A illustrates a system 800 for registering an anatomical feature of a patient using a DRB and an X-ray cone beam imaging device, according to some embodiments. An intraoperative scanner 852, such as an X-ray machine or other scanning device, may have a tracking array 854 with tracking markers 855, mounted thereon for registration. Based on the fixed, known position of the tracking array 854 on the scanning device, the system may be calibrated to directly map (register) the tracking space to the image space of any scan acquired by the system. Once registration is achieved, the registration, which is initially based on the tracking markers 855 (e.g. gantry markers) of the scanner's array 854, is related or transferred to the tracking markers 842 of a DRB 840, which may be fixed to a clamping fixture 830 holding the patient's head 828 by a mounting arm 841 or other rigid means. After transferring registration, the markers on the scanner are no longer used and can be removed, deactivated or covered if desired. Registering the tracking space to any image acquired by a scanner in this way may avoid the need for fiducials or other reference markers in the image space in some embodiments.

[0070] FIG. 8B illustrates an alternative system 800' that uses a portable intraoperative scanner, referred to herein as a C-arm scanner 853. In this example, the C-arm scanner 853 includes a c-shaped arm 856 coupled to a movable base 858 to allow the C-arm scanner 853 to be moved into place and removed as needed, without interfering with other aspects of the surgery. The arm 856 is positioned around the patient's head 828 intraoperatively, and the arm 856 is rotated and/or translated with respect to the patient's head 828 to capture the X-ray or other type of scan that to achieve registration, at which point the C-arm scanner 853 may be removed from the patient.

[0071] Another registration method for an anatomical feature of a patient, e.g., a patient's head, may be to use a surface contour map of the anatomical feature, according to some embodiments. A surface contour map may be constructed using a navigated or tracked probe, or other measuring or sensing device, such as a laser pointer, 3D camera, etc. For example, a surgeon may drag or sequentially touch points on the surface of the head with the navigated probe to capture the surface across unique protrusions, such as zygomatic bones, superciliary arches, bridge of nose, eyebrows, etc. The system then compares the resulting surface contours to contours detected from the CT and/or MR images, seeking the location and orientation of contour that provides the closest match. To account for movement of the patient and to ensure that all contour points are taken relative to the same anatomical feature, each contour point is related to tracking markers on a DRB on the patient at the time it is recorded. Since the location of the contour map is known in tracking space from the tracked probe and tracked DRB,

tracking-to-image registration is obtained once the corresponding contour is found in image space.

[0072] FIG. 9 illustrates a system 900 for registering an anatomical feature of a patient using a navigated or tracked probe and fiducials for point-to-point mapping of the anatomical feature 928 (e.g., a patient's head), according to some embodiments. Software would instruct the user to point with a tracked probe to a series of anatomical landmark points that can be found in the CT or MR image. When the user points to the landmark indicated by software, the system captures a frame of tracking data with the tracked locations of tracking markers on the probe and on the DRB. From the tracked locations of markers on the probe, the coordinates of the tip of the probe are calculated and related to the locations of markers on the DRB. Once 3 or more points are found in both spaces, tracking-to-image registration is achieved. As an alternative to pointing to natural anatomical landmarks, fiducials 954 (i.e., fiducial markers), such as sticker fiducials or metal fiducials, may be used. The surgeon will attach the fiducials 954 to the patient, which are constructed of material that is opaque on imaging, for example containing metal if used with CT or Vitamin E if used with MR. Imaging (CT or MR) will occur after placing the fiducials 954. The surgeon or user will then manually find the coordinates of the fiducials in the image volume, or the software will find them automatically with image processing. After attaching a DRB 940 with tracking markers 942 to the patient through a mounting arm 941 connected to a clamping apparatus 930 or other rigid means, the surgeon or user may also locate the fiducials 954 in physical space relative to the DRB 940 by touching the fiducials 954 with a tracked probe while simultaneously recording tracking markers on the probe (not shown) and on the DRB 940. Registration is achieved because the coordinates of the same points are known in the image space and the tracking space.

[0073] One use for the embodiments described herein is to plan trajectories and to control a robot to move into a desired trajectory, after which the surgeon will place implants such as electrodes through a guide tube held by the robot. Additional functionalities include exporting coordinates used with existing stereotactic frames, such as a Leksell frame, which uses five coordinates: X, Y, Z, Ring Angle and Arc Angle. These five coordinates are established using the target and trajectory identified in the planning stage relative to the image space and knowing the position and orientation of the ring and arc relative to the stereotactic frame base or other registration fixture.

[0074] As shown in FIG. 10, stereotactic frames allow a target location 1058 of an anatomical feature 1028 (e.g., a patient's head) to be treated as the center of a sphere and the trajectory can pivot about the target location 1058. The trajectory to the target location 1058 is adjusted by the ring and arc angles of the stereotactic frame (e.g., a Leksell frame). These coordinates may be set manually, and the stereotactic frame may be used as a backup or as a redundant system in case the robot fails or cannot be tracked or registered successfully. The linear x,y,z offsets to the center point (i.e., target location 1058) are adjusted via the mechanisms of the frame. A cone 1060 is centered around the target location 1058, and shows the adjustment zone that can be achieved by modifying the ring and arc angles of the Leksell or other type of frame. This figure illustrates that a stereotactic frame with ring and arc adjustments is well suited for

reaching a fixed target location from a range of angles while changing the entry point into the skull.

[0075] FIG. 11 illustrates a two-dimensional visualization of virtual point rotation mechanism, according to some embodiments. In this embodiment, the robotic arm is able to create a different type of point-rotation functionality that enables a new movement mode that is not easily achievable with a 5-axis mechanical frame, but that may be achieved using the embodiments described herein. Through coordinated control of the robot's axes using the registration techniques described herein, this mode allows the user to pivot the robot's guide tube about any fixed point in space. For example, the robot may pivot about the entry point 1162 into the anatomical feature 1128 (e.g., a patient's head). This entry point pivoting is advantageous as it allows the user to make a smaller burr hole without limiting their ability to adjust the target location 1164 intraoperatively. The cone 1160 represents the range of trajectories that may be reachable through a single entry hole. Additionally, entry point pivoting is advantageous as it allows the user to reach two different target locations 1164 and 1166 through the same small entry burr hole. Alternately, the robot may pivot about a target point (e.g., location 1058 shown in FIG. 10) within the skull to reach the target location from different angles or trajectories, as illustrated in FIG. 10. Such interior pivoting robotically has the same advantages as a stereotactic frame as it allows the user to approach the same target location 1058 from multiple approaches, such as when irradiating a tumor or when adjusting a path so that critical structures such as blood vessels or nerves will not be crossed when reaching targets beyond them. Unlike a stereotactic frame, which relies on fixed ring and arc articulations to keep a target/pivot point fixed, the robot adjusts the pivot point through controlled activation of axes and the robot can therefore dynamically adjust its pivot point and switch as needed between the modes illustrated in FIGS. 10 and 11.

[0076] Following the insertion of implants or instrumentation using the robot or ring and arc fixture, these and other embodiments may allow for implant locations to be verified using intraoperative imaging. Placement accuracy of the instrument or implant relative to the planned trajectory can be qualitatively and/or quantitatively shown to the user. One option for comparing planned to placed position is to merge a postoperative verification CT image to any of the preoperative images. Once pre- and post-operative images are merged and plan is shown overlaid, the shadow of the implant on postop CT can be compared to the plan to assess accuracy of placement. Detection of the shadow artifact on post-op CT can be performed automatically through image processing and the offset displayed numerically in terms of millimeters offset at the tip and entry and angular offset along the path. This option does not require any fiducials to be present in the verification image since image-to-image registration is performed based on bony anatomical contours.

[0077] A second option for comparing planned position to the final placement would utilize intraoperative fluoro with or without an attached fluoro fixture. Two out-of-plane fluoro images will be taken and these fluoro images will be matched to DRRs generated from pre-operative CT or MR as described above for registration. Unlike some of the registration methods described above, however, it may be less important for the fluoro images to be tracked because the key information is where the electrode is located relative

to the anatomy in the fluoro image. The linear or slightly curved shadow of the electrode would be found on a fluoro image, and once the DRR corresponding to that fluoro shot is found, this shadow can be replicated in the CT image volume as a plane or sheet that is oriented in and out of the ray direction of the fluoro image and DRR. That is, the system may not know how deep in or out of the fluoro image plane the electrode lies on a given shot, but can calculate the plane or sheet of possible locations and represent this plane or sheet on the 3D volume. In a second fluoro view, a different plane or sheet can be determined and overlaid on the 3D image. Where these two planes or sheets intersect on the 3D image is the detected path of the electrode. The system can represent this detected path as a graphic on the 3D image volume and allow the user to reslice the image volume to display this path and the planned path from whatever perspective is desired, also allowing automatic or manual calculation of the deviation from planned to placed position of the electrode. Tracking the fluoro fixture is unnecessary but may be done to help de-warp the fluoro images and calculate the location of the x-ray emitter to improve accuracy of DRR calculation, the rate of convergence when iterating to find matching DRR and fluoro shots, and placement of sheets/planes representing the electrode on the 3D scan.

[0078] In this and other examples, it is desirable to maintain navigation integrity, i.e., to ensure that the registration and tracking remain accurate throughout the procedure. Two primary methods to establish and maintain navigation integrity include: tracking the position of a surveillance marker relative to the markers on the DRB, and checking landmarks within the images. In the first method, should this position change due to, for example, the DRB being bumped, then the system may alert the user of a possible loss of navigation integrity. In the second method, if a landmark check shows that the anatomy represented in the displayed slices on screen does not match the anatomy at which the tip of the probe points, then the surgeon will also become aware that there is a loss of navigation integrity. In either method, if using the registration method of CT localizer and frame reference array (FRA), the surgeon has the option to re-attach the FRA, which mounts in only one possible way to the frame base, and to restore tracking-to-image registration based on the FRA tracking markers and the stored fiducials from the CT localizer 536. This registration can then be transferred or related to tracking markers on a repositioned DRB. Once registration is transferred the FRA can be removed if desired.

[0079] Referring now to FIGS. 12-18 generally, with reference to the surgical robot system 100 shown in FIG. 1A, end-effector 112 may be equipped with components, configured, or otherwise include features so that one end-effector may remain attached to a given one of robot arms 104 without changing to another end-effector for multiple different surgical procedures, such as, by way of example only, Deep Brain Stimulation (DBS), Stereoelectroencephalography (SEEG), or Endoscopic Navigation and Tumor Biopsy. As discussed previously, end-effector 112 may be orientable to oppose an anatomical feature of a patient in the manner so as to be in operative proximity thereto, and, to be able to receive one or more surgical tools for operations contemplated on the anatomical feature proximate to the end-effector 112. Motion and orientation of end-effector 112 may be accomplished through any of the navigation, trajec-

tory guidance, or other methodologies discussed herein or as may be otherwise suitable for the particular operation.

[0080] End-effector 112 is suitably configured to permit a plurality of surgical tools 129 to be selectively connectable to end-effector 112. Thus, for example, a stylet 113 (FIG. 13) may be selectively attached in order to localize an incision point on an anatomical feature of a patient, or an electrode driver 115 (FIG. 14) may be selectively attached to the same end-effector 112.

[0081] With reference to the previous discussion of robot surgical system 100, a processor circuit, as well as memory accessible by such processor circuit, includes various sub-routines and other machine-readable instructions configured to cause, when executed, end-effector 112 to move, such as by GPS movement, relative to the anatomical feature, at predetermined stages of associated surgical operations, whether pre-operative, intra-operative or post-operative.

[0082] End-effector 112 includes various components and features to either prevent or permit end-effector movement depending on whether and which tools 129, if any, are connected to end-effector 112. Referring more particularly to FIG. 12, end-effector 112 includes a tool-insert locking mechanism 117 located on and connected to proximal surface 119. Tool-insert locking mechanism 117 is configured so as to secure any selected one of a plurality of surgical tools, such as the aforesaid stylet 113, electrode driver 115, or any other tools for different surgeries mentioned previously or as may be contemplated by other applications of this disclosure. The securing of the tool by tool-insert locking mechanism 117 is such that, for any of multiple tools capable of being secured to locking mechanism 117, each such tool is operatively and suitably secured at the predetermined height, angle of orientation, and rotational position relative to the anatomical feature of the patient, such that multiple tools may be secured to the same end-effector 112 in respective positions appropriate for the contemplated procedure.

[0083] Another feature of the end-effector 112 is a tool stop 121 located on distal surface 123 of end-effector 112, that is, the surface generally opposing the patient. Tool stop 121 has a stop mechanism 125 and a sensor 127 operatively associated therewith, as seen with reference to FIGS. 16, 19, and 20. Stop mechanism 125 is mounted to end-effector 112 so as to be selectively movable relative thereto between an engaged position to prevent any of the tools from being connected to end-effector 112 and a disengaged position which permits any of the tools 129 to be selectively connected to end-effector 112. Sensor 127 may be located on or within the housing of end-effector 112 at any suitable location (FIGS. 12, 14, 16) so that sensor 127 detects whether stop mechanism 125 is in the engaged or disengaged position. Sensor 127 may assume any form suitable for such detection, such as any type of mechanical switch or any type of magnetic sensor, including Reed switches, Hall Effect sensors, or other magnetic field detecting devices. In one possible implementation, sensor 127 has two portions, a Hall Effect sensor portion (not shown) and a magnetic portion 131, the two portions moving relative to each other so as to generate and detect two magnetic fields corresponding to respective engaged and disengaged position. In the illustrated implementation, the magnetic portion comprises two rare earth magnets 131 which move relative to the complementary sensing portion (not shown) mounted in the housing of end effector 112 in operative proximity to mag-

nets 131 to detect change in the associated magnetic field from movement of stop mechanism 125 between engaged and disengaged positions. In this implementation the Hall effect sensor is bipolar and can detect whether a North pole or South pole of a magnet opposes the sensor. Magnets 131 are configured so that the North pole of one magnet faces the path of the sensor and the South pole of the other magnet faces the path of the sensor. In this configuration, the sensor senses an increased signal when it is near one magnet (for example, in disengaged position), a decreased signal when it is near the other magnet (for example, in engaged position), and unchanged signal when it is not in proximity to any magnet. In this implementation, in response to detection of stop mechanism 125 being in the disengaged position shown in FIGS. 13 and 19, sensor 127 causes the processor of surgical robot system 100 to execute suitable instructions to prevent movement of end-effector 112 relative to the anatomical feature. Such movement prevention may be appropriate for any number of reasons, such as when a tool is connected to end-effector 112, such tool potentially interacting with the anatomical feature of the patient.

[0084] Another implementation of a sensor 127 for detecting engaged or disengaged tool stop mechanism 125 could comprise a single magnet behind the housing (not shown) and two Hall Effect sensors located where magnets 131 are shown in the preferred embodiment. In such a configuration, monopolar Hall Effect sensors are suitable and would be configured so that Sensor 1 detects a signal when the magnet is in proximity due to the locking mechanism being disengaged, while Sensor 2 detects a signal when the same magnet is in proximity due to the locking mechanism being engaged. Neither sensor would detect a signal when the magnet is between positions or out of proximity to either sensor. Although a configuration could be conceived in which a sensor is active for engaged position and inactive for disengaged position, a configuration with three signals indicating engaged, disengaged, or transitional is preferred to ensure correct behavior in case of power failure.

[0085] End-effector 112, tool stop 121, and tool-insert locking mechanism 117 each have co-axially aligned bores or apertures such that any selected one of the plurality of surgical tools 129 may be received through such bores and apertures. In this implementation end-effector has a bore 133 and tool stop 121 and tool-insert locking mechanism 117 have respective apertures 135 and 137. Stop mechanism 125 includes a ring 139 axially aligned with bore 133 and aperture 135 of tool stop 121. Ring 139 is selectively, manually rotatable in the directions indicated by arrow A (FIG. 16) so as to move stop mechanism 125 between the engaged position and the disengaged position.

[0086] In one possible implementation, the selective rotation of ring 139 includes features which enable ring 139 to be locked in either the disengaged or engaged position. So, for example, as illustrated, a detent mechanism 141 is located on and mounted to ring 139 in any suitable way to lock ring 139 against certain rotational movement out of a predetermined position, in this case, such position being when stop mechanism 125 is in the engaged position. Although various forms of detent mechanism are contemplated herein, one suitable arrangement has a manually accessible head extending circumferentially outwardly from ring 139 and having a male protrusion (not shown) spring-loaded axially inwardly to engage a corresponding female detent portion (not shown). Detent mechanism 141, as such,

is manually actuatable to unlock ring 139 from its engaged position to permit ring 139 to be manually rotated to cause stop mechanism 125 to move from the engaged position (FIG. 20) to the disengaged position (FIG. 19).

[0087] Tool stop 121 includes a lever arm 143 pivotally mounted adjacent aperture 135 of tool stop 121 so end of lever arm 143 selectively pivots in the directions indicated by arrow B (FIGS. 16, 19 and 20). Lever arm 143 is operatively connected to stop mechanism 125, meaning it closes aperture 135 of tool stop 121 in response to stop mechanism 125 being in the engaged position, as shown in FIG. 20. Lever arm 143 is also operatively connected so as to pivot back in direction of arrow B to open aperture 135 in response to stop mechanism 125 being in the disengaged position. As such, movement of stop mechanism 125 between engaged and disengaged positions results in closure or opening of aperture 135, respectively, by lever arm 143.

[0088] Lever arm 143, in this implementation, is not only pivotally mounted adjacent aperture 135, but also pivots in parallel with a distal plane defined at a distal-most point of distal surface 123 of end-effector 112. In this manner, any one of the surgical tools 129, which is attempted to be inserted through bore 133 and aperture 135, is stopped from being inserted past the distal plane in which lever arm 143 rotates to close aperture 135.

[0089] Turning now to tool-insert locking mechanism 117 (FIG. 13, 17, 18), a connector 145 is configured to meet with and secure any one of the surgical tools 129 at their appropriate height, angle of orientation, and rotational position relative to the anatomical feature of the patient. In the illustrated implementation, connector 145 comprises a rotatable flange 147 which has at least one slot 149 formed therein to receive therethrough a corresponding tongue 151 associated with a selected one of the plurality of tools 129. So, for example, in FIG. 14, the particular electrode driver 115 has multiple tongues, one of which tongue 151 is shown. Rotatable flange 147, in some implementations, may comprise a collar 153, which collar, in turn, has multiple ones of slots 149 radially spaced on a proximally oriented surface 155, as best seen in FIG. 12. Multiple slots 147 arranged around collar 153 are sized or otherwise configured so as to receive therethrough corresponding ones of multiple tongues 151 associated with a selected one of the plurality of tools 129. Therefore, as seen in FIG. 13, multiple slots 149 and corresponding tongues 151 may be arranged to permit securing of a selected one of the plurality of tools 129 only when selected tool is in the correct, predetermined angle of orientation and rotational position relative to the anatomical feature of the patient. Similarly, with regard to the electrode driver shown in FIG. 14, tongues 151 (one of which is shown in a cutaway of FIG. 14) have been received in radially spaced slots 149 arrayed so that electrode driver 115 is received at the appropriate angle of orientation and rotational position.

[0090] Rotatable flange 147 has, in this implementation, a grip 173 to facilitate manual rotation between an open and closed position as shown in FIGS. 17 and 18, respectively. As seen in FIG. 17, multiple sets of mating slots 149 and tongues 151 are arranged at different angular locations, in this case, locations which may be symmetric about a single diametric chord of a circle but otherwise radially asymmetric, and at least one of the slots has a different dimension or extends through a different arc length than other slots. In this slot-tongue arrangement, and any number of variations

contemplated by this disclosure, there is only one rotational position of the tool 129 (or adapter 155 discussed later) to be received in tool-insert locking mechanism 117 when rotatable flange 147 is in the open position shown in FIG. 17. In other words, when the user of system 100 moves a selected tool 129 (or tool adapter 155) to a single appropriate rotational position, corresponding tongues 151 may be received through slots 149. Upon placement of tongues 151 into slots 149, tongues 151 confront a base surface 175 within connector 145 of rotatable flange 147. Upon receiving tongues 151 into slots 149 and having them rest on underlying base surface 175, dimensions of tongues 151 and slots 149, especially with regard to height relative to rotatable flange 147, are selected so that when rotatable flange 147 is rotated to the closed position, flange portions 157 are radially translated to overlie or engage portions of tongues 151, such engagement shown in FIG. 18 and affixing tool 129 (or adapter 155) received in connector 145 at the desired, predetermined height, angle of orientation, and rotational position relative to the anatomical feature of the patient.

[0091] Tongues 151 described as being associated with tools 129 may either be directly connected to such tools 129, and/or tongues 151 may be located on and mounted to the above-mentioned adapter 155, such as that shown in FIGS. 12, 17 and 18, such adapter 155 configured to interconnect at least one of the plurality of surgical tools 129 with end-effector 112. In the described implementation, adapter 155 includes two operative portions—a tool receiver 157 adapted to connect the selected one or more surgical tools 129, and the second operative part being one or more tongues 151 which may, in this implementation, be mounted and connected to the distal end of adapter 155.

[0092] Adapter 155 has an outer perimeter 159 which, in this implementation, is sized to oppose an inner perimeter 161 of rotatable flange 147. Adapter 155 extends between proximal and distal ends 163, 165, respectively and has an adapter bore 167 extending between ends 163, 165. Adapter bore 167 is sized to receive at least one of the plurality of surgical tools 129, and similarly, the distance between proximal and distal ends 163, 165 is selected so that at least one of tools 129 is secured to end-effector 112 at the predetermined, appropriate height for the surgical procedure associated with such tool received in adapter bore 167.

[0093] In one possible implementation, system 100 includes multiple ones of adapter 155, configured to be interchangeable inserts 169 having substantially the same, predetermined outer perimeters 159 to be received within inner perimeter 161 of rotatable flange 147. Still further in such implementation, the interchangeable inserts 169 have bores of different, respective diameters, which bores may be selected to receive corresponding ones of the tools 129 therein. Bores 167 may comprise cylindrical bushings having inner diameters common to multiple surgical tools 129. One possible set of diameters for bores 167 may be 12, 15, and 17 millimeters, suitable for multiple robotic surgery operations, such as those identified in this disclosure.

[0094] In the illustrated implementation, inner perimeter 161 of rotatable flange 147 and outer perimeter 159 of adapter 155 are circular, having central, aligned axes and corresponding radii. Slots 149 of rotatable flange 147 extend radially outwardly from the central axis of rotatable flange 147 in the illustrated implementation, whereas tongues 151 of adapter 155 extend radially outwardly from adapter 155.

[0095] In still other implementations, end-effector 112 may be equipped with at least one illumination element 171 (FIGS. 14 and 15) orientable toward the anatomical feature to be operated upon. Illumination element 171 may be in the form of a ring of LEDs 177 (FIG. 14) located within adapter 167, which adapter is in the form of a bushing secured to tool locking mechanism 117. Illumination element 171 may also be a single LED 179 mounted on the distal surface 123 of end-effector 112. Whether in the form of LED ring 177 or a single element LED 179 mounted on distal surface of end-effector 112, or any other variation, the spacing and location of illumination element or elements 171 may be selected so that tools 129 received through bore 133 of end-effector 112 do not cast shadows or otherwise interfere with illumination from element 171 of the anatomical feature being operated upon.

[0096] The operation and associated features of end-effector 112 are readily apparent from the foregoing description. Tool stop 121 is rotatable, selectively lockable, and movable between engaged and disengaged positions, and a sensor prevents movement of end-effector 112 when in such disengaged position, due to the potential presence of a tool which may not be advisably moved during such disengaged position. Tool-insert locking mechanism 117 is likewise rotatable between open and closed positions to receive one of a plurality of interchangeable inserts 169 and tongues 151 of such inserts, wherein selected tools 129 may be received in such inserts 169; alternately, tongues 151 may be otherwise associated with tools 129, such as by having tongues 151 directly connected to such tools 129, which tongue-equipped tools likewise may be received in corresponding slots 149 of tool-insert locking mechanism 117. Tool-insert locking mechanism 117 may be rotated from its open position in which tongues 151 have been received in slots 149, to secure associated adapters 155 and/or tools 129 so that they are at appropriate, respective heights, angles of orientation, and rotational positions relative to the anatomical feature of the patient.

[0097] For those implementations with multiple adapters 155, the dimensions of such adapters 155, including bore diameters, height, and other suitable dimensions, are selected so that a single or a minimized number of end-effectors 112 can be used for a multiplicity of surgical tools 129. Adapters 155, such as those in the form of interchangeable inserts 169 or cylindrical bushings, may facilitate connecting an expanded set of surgical tools 129 to the end-effector 112, and thus likewise facilitate a corresponding expanded set of associated surgical features using the same end-effector 112.

[0098] Another possible embodiment of surgical robot system 100 shown in FIG. 1A is described below and shown with reference to FIGS. 21-25. In this implementation, end-effector 212 is suitably connected to a robot arm, such as that described previously with reference to robot arm 104, and is orientable to oppose an anatomical feature so as to be in operative proximity thereto. End-effector 212 may include features similar to those described with reference to end-effector 112 of FIGS. 12-18, such as a tool-insert locking mechanism 217 and tool stop 221, which correspond to tool-insert locking mechanism 117 and tool stop 121 described previously. However, it will be appreciated that such features are not required in end-effector 212 and

various other features or configurations of end-effector 212 are contemplated by the disclosure with reference to FIGS. 19-24.

[0099] End-effector 212 has a surgical tool comprising a drill 223 selectively connectible thereto. Processing circuitry, memory, and suitable machine-readable instructions are associated with this implementation of surgical robot system 100 so as to determine, for drill 223, a drill target and an associated drill trajectory relative to anatomical feature a. Suitable instructions are likewise provided such that, when executed, the end-effector may be automatically moved to a position corresponding to the determined target and determined drill trajectory. Such instructions also permit advancement of the drill toward the target. Manual manipulations of end effector 212 to drill locations and trajectories are likewise contemplated.

[0100] A drill guide 225 is releasably connected between drill 223 and end-effector 212. As explained below, drill guide 225 may be configured and otherwise includes features to stop advancement of drill 223 at a preselected drill depth associated with the determined target. Drill guide 225 may be further configured with features to guide the drill along the determined drill trajectory during the advancement of the drill.

[0101] Drill guide 225 includes a guide shaft 227 having a bore 229 extending longitudinally therethrough between proximal and distal ends of guide shaft 227. Bore 229 is sized to slideably receive a drill bit 231 which extends distally from a chuck 233 of drill 223. Such drill bit 231 terminates in a drill tip 235 capable of engaging the anatomical feature a upon a suitable amount of advancement of drill bit 231 along the determined drill trajectory.

[0102] Referring more particularly to FIG. 22, drill bit 231 has a known, that is, predetermined, length A corresponding to the distance between the distal surface 237 of chuck 233 and the end of drill tip 235. Guide shaft 227, in turn, has a known, that is, predetermined, second length B. Drill guide 225 includes a depth stop 239 having respective proximal and distal depth stop ends. Depth stop 239 is mounted so that its distal depth stop end is selectively and slideably received at the proximal end of guide shaft 227. As such, depth stop 239, when slid relative to guide shaft 227, varies the second length B of guide shaft 227. In particular, movement of depth stop 239 varies the predetermined length B of guide shaft 227 among a plurality or set of length values corresponding to amounts by which drill tip 235 extends beyond distal end of guide shaft 227, such amounts thus corresponding to available drill depths. As such selected lengths B are less than the known, predetermined length A of drill bit 231, and thereby permit the distal end of drill bit 231 and its drill tip 235 to extend distally from the distal end of guide shaft 227 by selected lengths corresponding to desired depths of engagement of the anatomical feature. In the disclosed implementation, depth stop 239 has surface 241 oriented and located to engage a distal surface 237 of chuck 233 of drill 223. Accordingly, the depth to which drill tip 235 is advanceable by drill 223 is limited by an amount corresponding to the position of depth stop 239.

[0103] In one possible implementation, drill guide 225 includes a visually perceptible depth indicator 251 operatively associated with depth stop 239. By way of example, depth stop 239 has a longitudinal stem 245 having indicia 243 disposed thereon, so that slideable movement of depth stop 239 slides longitudinal stem 245 and the indicia 243.

Guide shaft 227, in turn, has portions forming a window 247 sized and located to reveal at least a portion of longitudinal stem 245 bearing indicia 243. The portions adjacent to window 247 have one or more structures or indicia thereon to form a pointer 249. Indicia 243, in this case, includes a graduated, numerical value scale associated with available depths of penetration of anatomical feature a, the pointer and numerical value scale being moveable relative to each other, in this case by sliding longitudinal stem 245 of depth stop 239 relative to window 247 of guide shaft 227.

[0104] It will be appreciated that the above-described relative arrangement of pointer 249 and graduated depths of advancement appearing as numerical values in indicia 243 may be disposed in alternative configurations, such as having the pointer on the slideable longitudinal stem 245 and the graduated depths of advancement disposed longitudinally along portions of window 247. Still further variations are possible.

[0105] In still further possible implementation, drill guide 225 makes use of an engagement mechanism 253 which sets depth stop 239 at one of the available, selectable, longitudinal positions corresponding to the desired or predetermined drill depth. Engagement mechanism 253 may include a ratchet assembly 255 which has features, such as mating teeth 257 as shown, to engage and set depth stop 239 at one of the longitudinally spaced locations between the proximal and distal ends of depth stop 239. In the ratchet assembly 255 shown, teeth 257 are longitudinally disposed along a suitable outer surface of longitudinal stem 245, and a ratchet 259 with a confronting surface feature, such as one or more mating teeth 257, is located to oppose teeth 257 disposed on stem 245 and is spring-biased to selectively engage stem 245.

[0106] Ratchet 259 and corresponding ratchet assembly 255 may be operated by a spring-biased trigger 261. In the illustrated embodiment, trigger 261 is manually pulled against a spring-biasing force to disengage engagement mechanism 253 from a first one of the longitudinal positions to which it had been previously set. During such disengagement, depth stop 239 is operated to slide longitudinal stem 245 relative to guide shaft 227 to a selected or desired drill depth as indicated by pointer 249 relative to the scale of indicia 243. After movement of depth stop 239 to the desired longitudinal position, spring-biased trigger 261 may be released, allowing the spring-biased force to set engagement mechanism 253 at a second one of the available longitudinal positions, the second longitudinal position corresponding to the desired drill depth.

[0107] Once a desired drill depth has been set by the ratchet assembly or other features of engagement mechanism 253, such setting may be locked or secured against inadvertent movement by a trigger lock 263 which is operatively connected to trigger 261, meaning, when engaged, trigger lock 263 holds ratchet 259 engaged with corresponding teeth 257 of depth stop. In the illustrated implementation, trigger lock 263 may be in the form of a locking ring 265, which may be threadably or otherwise engaged to act as a stop against disengagement of mating teeth 257 of ratchet 259, or more generally, to prevent radially outward movement of ratchet 259 relative to the longitudinal axis of depth stop 239.

[0108] Actuation of engagement mechanism 253, including, for example, engagement and disengagement of depth stop 239, may be facilitated by providing drill guide 225

with a handle 267. Handle 267 may be pulled radially outwardly from the longitudinal axis of drill guide 225 and, by virtue of connection to engagement mechanism 253, such outward pulling of handle 267 overcomes longitudinally inward spring-biasing force and disengages engagement mechanism 253 from depth stop 239. Conversely, release of handle 267 after desired sliding of depth stop 239 relative to guide shaft 227 operates to set drill guide 225 at a desired drill depth.

[0109] In addition to limiting penetration of drill 223 to a desired drill depth, drill guide 225 may include features to reduce deviation of drill bit 231 from the determined drill trajectory β (FIG. 21). In one suitable implementation, such trajectory guiding features comprise at least one bushing 269 disposed within bore 229. Bushing or bushings 269 are sized to receive outer longitudinal surface 273 of drill bit 231 slideably and rotatably therethrough. Accordingly, bushing 269 has an internal diameter sized to not only moveably engage longitudinal surface 273, but to thereby exert a force shown having the direction of arrow F opposing lateral displacement of drill bit 231 within guide shaft 227 (FIG. 22). In one possible implementation, one bushing 269 is located within guide shaft 227 toward distal end thereof and thereby engages drill bit 231 closer to where drill tip 235 engages anatomical feature a. Such distal locations of drill bit 231 often experience greater lateral displacement forces by virtue of their proximity to anatomical feature a to be engaged, especially in the event the drill trajectory is at an oblique angle.

[0110] In the illustrated embodiment, a second bushing 269 is disposed at a proximal location along guide shaft 227 and thereby may generate a countervailing force opposing lateral displacement at the proximal end of drill bit 231, such as would result from a cantilevering of drill bit 231 upon oblique engagement of anatomical feature a.

[0111] From the foregoing description, operations and related methods of robot surgical system 100 and its drill guide 225 will be readily appreciated. For example, in one method of operation, drill 223 may be guided during robot-assisted surgery, including any of the surgeries described herein on anatomical feature a of a patient. A drill target and an associated drill trajectory are determined, such as by computer processing. End-effector 212 is manually or automatically moved to a position corresponding to the determined target and the determined drill trajectory. After or before such movement of end-effector 212, depth stop 239 may be mechanically or manually set to one of a plurality of selectable positions corresponding to the desired depth of advancement of the drill associated with the contemplated surgery on the anatomical feature. In this way, drill 223 is limited from penetrating the anatomical feature beyond the selected, desired depth.

[0112] In one possible method, the displacement of the depth stop is done with the aid of visually perceptible indicia corresponding to graduated depths of advancement of the drill and, upon such visual perception of the desired depth, the depth stop is secured at such desired position. To set the depth stop, a spring-biased trigger 261 is disengaged relative to depth stop 239 from a first position, depth stop 239 is then longitudinally slid relative to visually perceptible indicia 243 to a second position, such second position corresponding to the desired position of the depth stop and the desired depth of drilling on anatomical feature a. Once the desired depth has been selected by movement of depth stop 239,

trigger 261 is released to re-engage depth stop 239 at the desired position. Thereafter, trigger lock 263 may be further engaged to avoid inadvertent disengagement and potential movement of depth stop 239 and thereby avoid over drilling.

[0113] In the above-description of various embodiments of present inventive concepts, it is to be understood that the terminology used herein is for the purpose of describing particular embodiments only and is not intended to be limiting of present inventive concepts. Unless otherwise defined, all terms (including technical and scientific terms) used herein have the same meaning as commonly understood by one of ordinary skill in the art to which present inventive concepts belong. It will be further understood that terms, such as those defined in commonly used dictionaries, should be interpreted as having a meaning that is consistent with their meaning in the context of this specification and the relevant art and will not be interpreted in an idealized or overly formal sense unless expressly so defined herein.

[0114] When an element is referred to as being “connected”, “coupled”, “responsive”, or variants thereof to another element, it can be directly connected, coupled, or responsive to the other element or intervening elements may be present. In contrast, when an element is referred to as being “directly connected”, “directly coupled”, “directly responsive”, or variants thereof to another element, there are no intervening elements present. Like numbers refer to like elements throughout. Furthermore, “coupled”, “connected”, “responsive”, or variants thereof as used herein may include wirelessly coupled, connected, or responsive. As used herein, the singular forms “a”, “an” and “the” are intended to include the plural forms as well, unless the context clearly indicates otherwise. Well-known functions or constructions may not be described in detail for brevity and/or clarity. The term “and/or” includes any and all combinations of one or more of the associated listed items.

[0115] It will be understood that although the terms first, second, third, etc. may be used herein to describe various elements/operations, these elements/operations should not be limited by these terms. These terms are only used to distinguish one element/operation from another element/operation. Thus a first element/operation in some embodiments could be termed a second element/operation in other embodiments without departing from the teachings of present inventive concepts. The same reference numerals or the same reference designators denote the same or similar elements throughout the specification.

[0116] As used herein, the terms “comprise”, “comprising”, “comprises”, “include”, “including”, “includes”, “have”, “has”, “having”, or variants thereof are open-ended, and include one or more stated features, integers, elements, steps, components or functions but does not preclude the presence or addition of one or more other features, integers, elements, steps, components, functions or groups thereof. Furthermore, as used herein, the common abbreviation “e.g.”, which derives from the Latin phrase “*exempli gratia*,” may be used to introduce or specify a general example or examples of a previously mentioned item, and is not intended to be limiting of such item. The common abbreviation “i.e.”, which derives from the Latin phrase “*id est*,” may be used to specify a particular item from a more general recitation.

[0117] Example embodiments are described herein with reference to block diagrams and/or flowchart illustrations of computer-implemented methods, apparatus (systems and/or

devices) and/or computer program products. It is understood that a block of the block diagrams and/or flowchart illustrations, and combinations of blocks in the block diagrams and/or flowchart illustrations, can be implemented by computer program instructions that are performed by one or more computer circuits. These computer program instructions may be provided to a processor circuit of a general purpose computer circuit, special purpose computer circuit, and/or other programmable data processing circuit to produce a machine, such that the instructions, which execute via the processor of the computer and/or other programmable data processing apparatus, transform and control transistors, values stored in memory locations, and other hardware components within such circuitry to implement the functions/acts specified in the block diagrams and/or flowchart block or blocks, and thereby create means (functionality) and/or structure for implementing the functions/acts specified in the block diagrams and/or flowchart block(s).

[0118] These computer program instructions may also be stored in a tangible computer-readable medium that can direct a computer or other programmable data processing apparatus to function in a particular manner, such that the instructions stored in the computer-readable medium produce an article of manufacture including instructions which implement the functions/acts specified in the block diagrams and/or flowchart block or blocks. Accordingly, embodiments of present inventive concepts may be embodied in hardware and/or in software (including firmware, resident software, micro-code, etc.) that runs on a processor such as a digital signal processor, which may collectively be referred to as "circuitry," "a module" or variants thereof.

[0119] It should also be noted that in some alternate implementations, the functions/acts noted in the blocks may occur out of the order noted in the flowcharts. For example, two blocks shown in succession may in fact be executed substantially concurrently or the blocks may sometimes be executed in the reverse order, depending upon the functionality/acts involved. Moreover, the functionality of a given block of the flowcharts and/or block diagrams may be separated into multiple blocks and/or the functionality of two or more blocks of the flowcharts and/or block diagrams may be at least partially integrated. Finally, other blocks may be added/inserted between the blocks that are illustrated, and/or blocks/operations may be omitted without departing from the scope of inventive concepts. Moreover, although some of the diagrams include arrows on communication paths to show a primary direction of communication, it is to be understood that communication may occur in the opposite direction to the depicted arrows.

[0120] Although several embodiments of inventive concepts have been disclosed in the foregoing specification, it is understood that many modifications and other embodiments of inventive concepts will come to mind to which inventive concepts pertain, having the benefit of teachings presented in the foregoing description and associated drawings. It is thus understood that inventive concepts are not limited to the specific embodiments disclosed hereinabove, and that many modifications and other embodiments are intended to be included within the scope of the appended claims. It is further envisioned that features from one embodiment may be combined or used with the features from a different embodiment(s) described herein. Moreover, although specific terms are employed herein, as well as in the claims which follow, they are used only in a generic and descriptive

sense, and not for the purposes of limiting the described inventive concepts, nor the claims which follow. The entire disclosure of each patent and patent publication cited herein is incorporated by reference herein in its entirety, as if each such patent or publication were individually incorporated by reference herein. Various features and/or potential advantages of inventive concepts are set forth in the following claims.

What is claimed is:

1. A surgical robot system for surgery on an anatomical feature of a patient, the system comprising:

- a surgical robot;
- a robot arm connected to the surgical robot;
- an end-effector connected to the robot arm and orientable to oppose the anatomical feature so as to be in operative proximity thereto;
- a processor circuit;
- a surgical tool comprising a drill selectively connectible to the end-effector;
- a memory accessible by the processor circuit and comprising machine readable instructions configured, in response to user input, to determine a drill target and an associated drill trajectory, the instructions further configured, when executed, to cause the end-effector to move to a position corresponding to a determined target and a determined drill trajectory to permit advancement of the drill toward the target;
- a drill guide having proximal and distal ends, the drill guide releaseably connected to the end-effector at the distal end and to the drill at the proximal end, wherein the drill guide is configured to stop the advancement of the drill at a pre-selected drill depth associated with the determined target and is further configured to guide the drill along the determined drill trajectory during the advancement of the drill;
- wherein the drill includes a chuck having a distal surface and a rotatable, elongated drill bit extending distally from the distal surface of the chuck and terminating in a drill tip capable of engaging the anatomical feature, the drill bit having a first predetermined length corresponding to the distance between the distal surface of the chuck and the drill tip;
- wherein the drill guide includes a guide shaft having proximal and distal guide shaft ends, openings at the proximal and distal guide shaft ends, respectively, and a bore extending between the openings and sized to slideably receive the drill bit therethrough, the guide shaft having associated therewith a second, predetermined length;
- wherein the drill guide further includes a depth stop having proximal and distal depth stop ends, the depth stop mounted to the proximal end of the guide shaft and selectively slidable longitudinally to vary the second predetermined length to be shorter than the first predetermined length of the drill bit, so that the drill bit when received in the guide shaft may be advanced beyond the distal end of the guide shaft by a preselected amount;
- wherein the depth stop has a surface for engaging the distal surface of the chuck of the drill, whereby the depth to which the drill tip is advanceable by the drill is limited by an amount corresponding to the position of the depth stop.

2. The system of claim 1, wherein the drill guide comprises a depth indicator having indicia corresponding to graduated depths of advancement of the drill bit associated with the drill guide.

3. The system of claim 2, wherein the depth stop comprises a longitudinal stem slideably received within the bore of the guide shaft;

wherein the guide shaft has portions forming a window sized and located to reveal the longitudinal stem received in the guide shaft; wherein the indicia associated with the graduated depths are located on at least one of the stem and the portions adjacent the window to indicate the predetermined drill depth.

4. The system of claim 3, wherein the indicia comprise a pointer and a numerical value scale moveable relative to each other, the pointer disposed on one of the stem and the portions adjacent the window, and the numerical value scale disposed on the other of the stem and the portions adjacent the window.

5. The system of claim 1, wherein the drill guide comprises an engagement mechanism to set the depth stop at one of a plurality of selectable, longitudinal positions corresponding to a desired drill depth.

6. The system of claim 5, wherein the engagement mechanism comprises a ratchet assembly engageable at one of the plurality of longitudinally spaced locations between the proximal and distal ends of the depth stop.

7. The system of claim 5, wherein the drill guide comprises a spring-biased trigger actuatable to disengage the engagement mechanism from a first one of the longitudinal positions and set the engagement mechanism at a second one of the longitudinal positions, the second longitudinal position corresponding to the desired drill depth.

8. The system of claim 7, wherein the trigger comprises a trigger lock operatively connected to the trigger to inhibit the actuation of the trigger and thereby inadvertent disengagement of the engagement mechanism.

9. The system of claim 5, wherein the drill guide comprises a handle operatively connected to the engagement mechanism to manually set the depth stop at the selective one of the longitudinal positions.

10. The system of claim 1, wherein the guide shaft has at least one bushing disposed within the bore and sized to receive the outer longitudinal surface of the drill bit slideably and rotatably therein.

11. The system of claim 10, wherein the guide shaft comprises upper and lower bushings disposed at longitudinally-spaced locations within the bore.

12. The system of claim 10, wherein the bushing has an internal diameter sized to engage the longitudinal surface of the distal end of the drill bit with a force opposing lateral displacement of the drill bit within the guide shaft to reduce deviation of the drill bit from the determined drill trajectory.

13. A method of guiding a drill during robot-assisted surgery on an anatomical feature of a patient, the method comprising the steps of:

determining, by computer processing, a drill target and an associated drill trajectory and effectuating movement of an end-effector to a position corresponding to the determined target and the determined drill trajectory; manually setting a depth stop connected to the end-effector to one of a plurality of selectable positions corresponding to a desired depth of advancement of the drill relative to the anatomical feature, whereby the drill is limited from penetrating the anatomical feature beyond the desired depth.

14. The method of claim 13, wherein the step of setting the depth stop comprises:

displacing the depth stop relative to visually perceptible indicia, the indicia corresponded to graduated depths of advancement of the drill; and securing the depth stop at a desired position corresponding to a selected one of the graduated depths.

15. The method of claim 14, wherein the steps of displacing and securing the depth stop comprise:

actuating a spring-biased trigger to disengage the depth stop from a first position; longitudinally sliding the depth stop relative to the visually perceptible indicia to a second position, the second position corresponding to the desired position of the depth stop; and releasing the trigger to re-engage the depth stop at the desired position.

* * * * *