

Great Ormond Street Hospital for Children



NHS Trust

23rd March 2004

Mr Mark Spinoza
Trust Doctor
GOSH

Dear Mark,

Re: Declarant

1. Identification of Declarant

I, Martin John Elliott declare that I am Chief of Cardiothoracic Surgery and Transplantation at the Great Ormond Street Hospital for Children NHS Trust, London WC1N 3JH

2. Qualifications of Declarant

I am a Medical Practitioner qualifying in 1973 as MBBS, receiving the academic qualification of MD (Doctorate at Medicine, similar to an American PhD) in 1983, and becoming a fellow of the Royal College of Surgeons in 1978. I trained as a General Surgeon, an adult Cardiac Surgeon, and finally as a Paediatric Cardiac Surgeon and am now a Consultant Paediatric Cardiothoracic Surgeon at the Great Ormond Street Hospital for Children, London. I have been practicing there as a Consultant (attending) since 1985 and am now Chief of Cardiothoracic Surgery and Transplantation. To date I have published 145 peer reviewed papers, 20 invited articles, 3 books and 27 chapters in books. I have given 246 invited lectures of which 10 have been plenary lectures. These have been delivered at centres and meetings throughout the world. I am considered by others as an expert in cardiopulmonary bypass, paediatric thoracic surgery and the surgery for congenital heart defects, in addition to transplantation. I have been working in the field of cardiothoracic surgery including in children since 1978.

3. Purpose of Declaration

As it stands.

4. General View of the Present Invention

Dr Spinoza has sent me a copy of the present patent application which I have reviewed, I have also seen a prototype device which is based on the device shown in figure X of the patent.

My impressions are that this is a simple, elegant and clever idea and design, which will have widespread applicability in my field. It's versatility means that once established, it should be applicable in numerable circumstances in which tubes or cables can be fixed to a child's skin, resulting in minimal trauma and great safety, a key element in the design of such a product. Current practice of the insertion of for example chest drains into a child is that a hole is first made in the body and the chest drain inserted, and then in order to fix the chest drain to the skin to stop it moving, a suture is first passed through the skin and then wrapped around the plastic tube of the drain to hold it in place. This is inherently difficult, the drain is prone to movement, the stitch prone to fracture and the forces exerted on the suture are very localised, making it possible also to damage the drain. To prevent movement of the drain in the skin and out of the child the drain is frequently taped to the side of the chest further adding to the discomfort, and in many occasions preventing visualisation of the skin area.

Previous attempts to solve the issue of drain fixation have involved a variety of taping solutions, additional sutures and so on. All of these result in considerable discomfort for the child.



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