AtriCure at Morgan Stanley

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Cecilia Furlong: Good afternoon. Thank you for joining us for the second day of the Morgan Stanley Healthcare Conference. I'm Cecilia Furlong, a medical device analyst here at Morgan Stanley. It's my pleasure to have AtriCure with us. CEO, Mike Carrel, thank you again for being here with us.

Michael Carrel: Great to be here. Thanks for having us.

Cecilia Furlong: And really quickly, disclosures, see morganstanley.com/researchdisclosures.

But with that, I wanted to start with the macro, what you've seen in terms of staffing, other dynamics in your business. And then really speak to kind of -- I think we've had some questions in terms of CONVERGE specifically, and I want to spend some time on that. But what have been the biggest challenges as you think about just bringing this procedure up during COVID? There are a lot of logistical challenges. Getting the patients in, scheduling, dynamics between the surgeon, the EP. Can you just talk about kind of how much of an impact that has had? And what's factored into your back half guidance in terms of how that progresses?

Michael Carrel: Sure. I'll start with the macro set. It seems like that's the question du jour as we go into the one-on-ones today as everyone's asking about the macro environment. What we've seen -- and obviously we're a small slice of the world. We don't have the broad-based business that others might have. But we're definitely seeing an improvement overall. I've heard people say that they're getting back to the old normal. I'd say it's more of a new normal relative to staffing, because I think that we're still going to have staffing issues that the hospitals are going to have to deal with. But affecting procedures, not really as much anymore at this point in time. I think that you're not seeing it affect their ability to kind of ramp up and do the procedures and get the volumes that they need in cardiac surgery in the core areas that we have relative to staffing.

COVID's still there. You definitely still see patient cancellations and things like that happening on the COVID side more so than, call it, before COVID, of course. But it's a lot better than it was in Q2 and definitely better than it was kind of at the end of last year and the early part of this year.

The second part of your question I think was around CONVERGE, which is also obviously the question that a lot of people are asking. That was definitely affected -- it was the most affected in our business relative to COVID and staffing. Because when that came in, delta and omicron, as we were making great progress in getting sites up and running, people tended to say, you know what, let's push off starting that brand new

practice and program that we were going to do, or let's push off those patients just a little bit. And we definitely saw that hit us in Q4 and Q1. What you saw in Q2 for us was a nice ramp-up back. We saw a 20% sequential growth, 12% year-over-year growth on the CONVERGE side of our business as we kind of got that up and running.

So what we're hearing on CONVERGE, and in my mind, it's actually gone, given the circumstance and what's happened from a COVID standpoint and staffing, I feel like we're in a great spot relative to that procedure. Why? The data came out, and the data is excellent. What do I mean by that? The first thing you've got to do is you've got to convince and electrophysiologist that this procedure makes sense for them. And our procedure is additive to that, and they're going to be able to treat a patient population that they can't treat today, which is the longstanding, persistent atrial fibrillation patient. This patient has been in Afib for more than a year, and the catheters today do not work in that patient population well. In fact, our trial, what it showed was at 18 months, you had a 110% improvement from the catheter arm to our arm. What do I mean? 26% success rate in the catheter arm. 61% success.

So the first thing you do is you show that information and they get excited about it because they're like, wait a second, this is -- I have a solution for patients I could otherwise not treat. That actually part has been the easy part in terms of getting the data. Now that the data's out there, that part's easy.

The second part is really, okay, now I've got to get a surgeon to get excited about it and get a surgeon to work with that electrophysiologist and say, I'm going to go commit my career and a portion of my career to treating the atrial fibrillation. And they've got to feel like they're going to get enough referral base relative to that.

The good news for us is that we've got a great cardiac surgery team. We've got 130 or so people out on the cardiac surgery side, 60 people on this side. That part has actually gone reasonably well, too, in terms of pairing them up, getting them trained. We've trained well over 100 or so people over the course of the last year. So, made great progress in that area in terms of just kind of getting surgeons to be really bought in and partnering.

Then really where the headwind, per se, comes in is how do you get them through the workflow? How do you get them to sit down and say, it's great; you believe in it and you believe you're going to have this. Now let's get them to work together and actually figure out how we're going to treat these patients and how -- am I going to stage it? Am I going to do it the same day? That's where you get caught up with COVID and the impact of COVID from back in last year. Because you've made this momentum, you've gotten them together, and then now it's about getting them to get comfortable about how they're going to actually manage that patient flow.

And we're making good progress on that. But I'd say that's kind of getting them to be interested to kind of get that going through is now starting to begin to kind of pick up steam. And as I said, you saw in Q2 the uptake from Q1 to Q2. But that's kind of the biggest headwind is that logistic side of it. Hopefully that helps. I don't know if that's kind of --

Cecilia Furlong: Can I ask, too, as you look at the initial 12-month data and then the 18-month data and the increased delta just in -- versus just catheter alone in terms of durability. How much of an impact has that had?

Michael Carrel: Huge. Huge. When you talk to electrophysiologists, it's difficult for them to poke any

holes in the data. Because when they look at it and then they look at the fact that this is much more durable, they recognize the fact that they should have this in their practice. Because to them, there's really -- all this is is additive to their practice. It doesn't take away any of the catheters they're going to do. They're still part of the procedure. So I'd say that to most of them -- I'm going to say 90% of the EPs you talk to will say that. There's 10%, you're always going to have that 10% that's out there that is going to be naysayers and isn't going to want to partner with another specialty. But most of them understand the compelling nature of that data, and that has a big impact, for sure. Combined with other data coming out.

So for example, just recently, like two weeks ago at ESC, there was the CAPLA trial, which basically showed a PVI with a catheter versus a PVI in a posterior wall. Well, Convergent basically does the posterior wall from the outside, and so this was just for the catheter. And what it showed was there was no difference in that patient population when they did it with just a catheter, which shows you the benefit of adding that back wall ablation from the outside really creates it and makes it a lot more durable. And the buzz after that, just that data came out, in concert with the data that came out from us, it's kind of like building upon itself.

Cecilia Furlong: A few different questions. Where are you today in terms of just training on the procedure in terms of total accounts? And then you talked about a lot of the challenges in really a structure; getting the patient, the EP, the surgeon, all of that on board. How are you kind of formalizing that structure as you continue to train, roll out this procedure?

Michael Carrel: So from a training, we don't give a specific number of training. We've trained over 100 or so over the last -- since the approval. And we would do about 200 or so throughout a year in terms of sites, about 100 per quarter, and we've definitely seen much improvement over that relative to kind of number of sites and things. But we're not ready to do that because a lot of it is we're trying to get deeper into those sites to deal with the second part of your question. The second part of your question is how do you get that logistics to work out where you're kind of doing it.

And we're making progress. We're not quite there yet. I'd say that -- I got asked the question earlier today, how do you feel about the number of sites that you have up and running that are kind of at -- they're doing a quality account where they're doing 50-plus. So there's not many. We're not there yet. But we've got programs that are making really good progress to getting to that point where they're doing a case a week. And talk to me in a year and I think you're going to have a whole heck of a lot more, and I will say, we have a lot of sites at that point.

Cecilia Furlong: As you think about -- or just wanted to ask, too, percentage of procedures that are staged versus concomitant and performed today. And then just physician EP preference, specifically, having a staged procedure, has that been something just in terms of being able to actually be with the surgeons, then come back in? What are you seeing in the market today?

Michael Carrel: It's a great question because the trial was a same day procedure, and we anticipated that that might be the case that people would want to do it same day. But actually what we're seeing is 80% of our centers are now doing staged procedures. Almost 100% of our new sites are doing staged procedures. And it's actually very simple. Two major reasons. Number one is that the logistics make it a lot easier for that patient. So they come -- and for the physicians. They don't have to coordinate two different schedules. So they come in, they get the surgery, they go home for 6 to 8 weeks and then they come back. Very

easy to schedule. You don't have EPs and their staff waiting around for the surgery to be done. Reason number one.

Reason number two is they really like the fact that when they do that first ablation, they allow that ablation to settle down so that when they're doing the mapping later on, clinically, they're actually looking at more relevant, what is that block at that point in time. And they feel really good that they're getting a better PVI or a better touch-up procedure later on when they actually stage the procedure. So right now what you're seeing, we don't care one way or the other, but we definitely see that our clinicians prefer to go staged. And that is being driven by both EPs and surgeons. It's kind of being delivered by the collaboration between the two.

Cecilia Furlong: Do you think reimbursement at all is a factor there?

Michael Carrel: It doesn't really come up. We don't get into that conversation with them. We really focus on the clinical aspects of it. And depending on which way you're going to do it, we will help you through that. So that doesn't really come up in the conversation that we're having.

Cecilia Furlong: On the clip side, too, what is attachment rate today? And I want to get into the LeAAPS study, too. But as you think about just your underlying clip business, both ramp in CONVERGE, clip attachment in CONVERGE, and then a bit of benefit, perhaps, the next few years from LeAAPS. How do you think about just that growth?

Michael Carrel: So on the attachment rate, it's almost funny. When we bought this company back in 2015, which is a long time ago, we thought, oh, if we get the 5% attachment, we'll be really happy. We're at 75% attachment. Almost every new center that comes online now wants to add a clip to the Convergent procedure. In fact, the EPs are driving it. I'd say that they really believe that managing the appendage is the right thing to do, and we tend to have that as one of the big things that we have. And that adds additional training to it as well. So our teams are prepared and ready to train them on that.

But we feel really good about that. 75% is a really good number. I was asked today how high can that go. I think it can go higher, but I'm not ready to commit to that at this point. But again, almost every new site we get today is actually doing that. So you're right. As CONVERGE grows, our MIS clip number is going to grow along with it.

Cecilia Furlong: You also I think have an investor update coming up focused on CONVERGE. What is kind of the key objectives there and messaging you're looking to get across to investors?

Michael Carrel: We've been asked so many questions about CONVERGE, and everybody's just heard me talk about CONVERGE over and over. We're trying to give people a different perspective. Here are two great sites. Two sites that have got real programs in place. And we want to basically help people understand, here's how these programs developed. One program was a program that was developed pre the approval. Somebody that's been a part of the program, they were part of the clinical trial. And they now are up to doing like almost 80 patients per year.

But that journey has been about a 7-year journey. But since the approval, they have gone from about 40 patients per year to almost 80 patients as they add net new hospitals. So the impact to them was it no longer was just at MedStar, which is one of the largest hospitals in the country, as they're doing it at their mothership. But they're actually starting to do it at the community sites.

UCLA, other coast, did not do this beforehand. And the idea is to really kind of demonstrate how did they go from seeing the data, the data being convincing, to them then starting to kind of get a program going, testing it out, and now they're going to do almost over 40 cases this year.

So to kind of see that progression from kind of 0 to 40 over a 2.5 year period from seeing the data, we kind of want to give people that perspective and to hear from the clinicians themselves, sort of how did they make those decisions. So the idea is that, hey, this is why we think this is going to be successful long term. Listen to these really talented places that are doing great cardiac work and kind of hopefully take it from there. So the goal is just to get people's interest and get them to better understand what a real clinical setting looks like.

Cecilia Furlong: Last question on MIS and we can move on. But the legacy component of the MIS and the ex-nContacts part, I guess, that was volatile I think before you had CONVERGE approval and clearly is having an impact. How do you think about just at least communicating it to the Street, too, what you're seeing in that business versus the core CONVERGE? And how do you think about -- where is that today, and can that evolve into your CONVERGE business over time?

Michael Carrel: Yes. It's a great procedure. We call it the DEEP procedure. It works incredibly well. It's very efficacious. You get great results with the DEEP procedure. But we're in the middle of a clinical trial, and we don't anticipate -- it's also a much more difficult procedure for a surgeon to do. So it's not growing as fast. We're not adding in net new sites. Our focus has really been on CONVERGE because we feel like there's a better partnership with the EP as they go down that path.

We see the growth coming off of CONVERGE and that basically that portion of our business either staying stable or down slightly, but CONVERGE growing over time to basically continue to make it so that that overall piece of our business grows fast. We're not getting rid of it because it's actually a really good procedure, and those people that do it do a great job. The success rates are really good. And then there is clinical data that will come out from both DEEP, and then we have a trial over in Europe that we did several years ago. And we anticipate clinical data coming out probably in the next year or so that should hopefully be very supportive of that procedure as well.

Cecilia Furlong: What kind of percentage mix do you think if you have that --

Michael Carrel: Today it's about 70/30. 70% CONVERGE, 30% DEEP.

Cecilia Furlong: Does that shift, do you think, with the clinical data?

Michael Carrel: I don't think it shifts on the DEEP side. I think that CONVERGE will continue to take over and be even a much larger percentage in the years to come.

Cecilia Furlong: Got it. Wanted to switch to pain management, which has kind of been a rocket ship, to a certain degree. You started breaking it out this year. Where are you seeing adoption? Really, what is the driver of the adoption? You don't have incremental reimbursement today. It adds time to the procedure. So why has this gained the traction that it has?

Michael Carrel: This sounds crazy. It works. It works really well. When you see a patient that has cryo nerve block applied to their ribs or to their intercostal nerves when they're undergoing

thoracic surgery, they do better. They recover more quickly. You can see them sitting up and reading the newspaper 4 hours after surgery when it usually takes 2 days or so otherwise. This is something that works really well. These patients recover a lot quicker.

The reason it's gaining adoption is because you get a quick response. You do it and you see the results 4 hours later right after surgery. So as a result of that, people are like, well, I'm going to do it again. And then they just keep building on that and they just keep seeing that success. Their staff sees the success as they're kind of rounding afterwards and they start to see that, wow, these patients do so much better, and that's what really kind of builds upon itself. We're in over 400 centers today. That number continues to grow, and we're getting deeper within each one of the centers.

A big portion of this, it's all thoracotomies today. So it's all kind of coming into the thoracic space like a VATS procedure or a robotic VATS. Spread the ribs, and when you spread the ribs, you aggravate and make the nerves angry, basically, is probably the best way I've heard about it. They get really angry, and therefore, it hurts like heck. And so therefore by ablating it, it takes away that nerve blockage for about 6 to 8 weeks. And it's post the postop thing, and it also lasts 6 to 8 weeks. They feel confident that these people are going to be kind of pain free or a lot of reduced pain for a long period of time. So that's why it's taking off is because it's success -- because you can see it right in the patient right away.

Cecilia Furlong: I think you've talked about -- and correct me if I'm wrong, somewhere around 10% penetration in thoracotomies today. Where does that go 2 to 3 years from now? And as you think about either clinical data to support reimbursement, looking at kind of economic side of reducing like the -- how are you thinking about just that evolution in driving growth --

Michael Carrel: It's a good question. I'm not sure why it shouldn't be 100% at some point in time. It really works that well. Most of the cases, if you think about thoracotomies today, over 50% of those cases are for lung cancer patients where they're taking out a lobe. And that number's continuing to grow and increase in terms of the number of patients because they're doing earlier screening of those cancer patients and trying to get that before the cancer metastasizes. So that number continues to grow. And we anticipate that we can kind of continue to grow kind of our penetration kind of within that area. And that's just in the thoracotomy space.

We also see a possible expansion into sternotomy as well. Because right now, it's really just being used by the thoracic surgeon, but we do believe that there is an opportunity within a thoracotomy space. There's 255,000 sternotomies every year just in the United States. That number's about 750,000 globally. And we're right now rolling it out to just a small group of centers where we're testing it out and kind of getting good feedback on that. And that'll take us about a year to kind of get that feedback, and then we'll hopefully roll it out in a bigger way later on next year. That will open up the TAM quite dramatically at that point.

Cecilia Furlong: Is there device optimization, that you're thinking about a unique device for thoracotomy versus sternotomy?

Michael Carrel: You don't need it. We might work on some ergonomics on the actual deliver -- the energy and the way the energy is delivered is actually -- we studied that very hard to come up with a specific device, the cryoSPHERE, that we use for the thoracotomies. I will say that for the sternotomy, it's more going to be ergonomic around the handle just because you're

coming at it from a different angle, but they can use the one they've got today. It's actually bendable, and they can kind of put it into place. But we'll probably come out with something, but it'll be more of a minor improvement than a major improvement.

Cecilia Furlong: OUS expansion, too, how are you thinking about just the opportunities outside the US?

Michael Carrel: We've already got clearance for it in Europe. And in Australia, we've started to put a team in place. We're probably about 3 to 4 years behind the US in terms of just beginning to kind of get some of that traction.

And I didn't answer one of your questions. You asked about reimbursement and studies and things like that as well. Reimbursement is a critical piece, obviously, long term. It's not going to happen overnight. So much like what we saw in cardiac surgery, where data came out from a lot of individual studies over time, we just got $10,000 added to the reimbursement on the CABG plus ablation last October, about a year ago. That took over 10 years to get with a lot of clinical evidence and data.

So it's going to take some time to get CMS and other people there to make changes in that. But we're investing in those trials, so single center to prove that economic, but also just prove the clinical care basis for it as well. And those are things that we're kind of investing in kind of on the side. We don't need to do a full IDE on it, but investing in kind of small studies or kind of maybe some multicenter studies.

Cecilia Furlong: How do you think about, too, just looking for the balance in R&D dollars going toward cryo or pain management versus your core AF business?

Michael Carrel: That's a great question. A lot of the resources -- we don't need as much on the R&D side on cryo, because we were able to leverage the existing cryo box that we had that came from the cardiac side. That box works incredibly well. You combine that with we did make some investments in a cryoSPHERE product. Those are smaller investments relative to it. And we're not sure if we have to a full blown IDE because our labeling is actually very strong today. So the investment in R&D maybe isn't quite as heavy as it is like right now with the LeAAPS trial that you mentioned earlier where we've got to make a major investment in a new market opportunity for us on that side.

We think cryo, it's much more going to be about making investments in the team out in the field, the support team to make sure -- we're at over 50 people today. That number's going to continue to grow overall. That's a combination of clinicals and sales. That's where the big investment's going to be.

Cecilia Furlong: Turning to the clinical trials, LeAAPS, HEAL-IST. Starting with HEAL-IST, timelines, how you're thinking about that, but then why the focus now. And if you think about the US versus OUS, international, kind of receptivity, how you're thinking about enrollment in those two geographies. Can you just frame that --

Michael Carrel: HEAL-IST to me is a great example of a collaboration between a company, like industry and clinicians who found and were able to solve a problem out in the field. So your question was why now. Well, why now is because Dr. de Asmundis and Dr. LaMeir, who are the EP and the surgeon in Belgium who basically invented this procedure. And they found out -- they were looking for a problem. There are no solutions for patients. These are typically women ages 20 to 40 years old that basically have a high tachycardia where their resting heart rate is above 100. Most these patients are at like 140. So just imagine yourself trying to live your life, trying to fall asleep when your heart rate's at 140. You

can't. You can't eat, you can't sleep, you can't exercise. Basically, your life stops. And these patients are absolutely miserable.

Well, Dr. de Asmundis and Dr. LaMeir figured this out about 6 years ago. The drugs don't work. The catheter by itself didn't work. But when they combined it with surgery, they were able to kind of ablate in areas they could not get to with a catheter. As a result, they came up with this procedure. They then published the paper that just got published last year, which was the trigger for us to be able to go do a clinical trial. They've now done this in over 250 patients. They've seen almost 100% success. I know that sounds crazy, but they've literally seen almost 100% success in their patient population. And these patients are incredibly happy.

Now, we've brought it over to the US. We're starting to train sites, and we talked to the FDA about we want to be able to bring this to all the centers in the US. So our plan is to train. We've trained about 15 centers right now to get them all into the clinical trial. We can go up to about 27. We anticipate it's 142 or so patients that we're going to enroll in this. And the market for it is, you think it's a small market, there are over a million patients that actually have IST in the United States alone. So it's a very large patient population. And if you can capture a small percentage of that, call it, even if you just captured 2% of that patient population, you're talking about a $200 million to $250 million a year annualized opportunity just in the US alone, let alone in Europe where it was originated.

Cecilia Furlong: LeAAPS, it's the other clinical trial, too. Can you just give us an update, how you're thinking about enrollment, commencement of enrollment. But then same question. Why now?

Michael Carrel: LeAAPS is another one that we've been studying it for a long time. So again, what LeAAPS is, is a cardiac surgery patient. They don't have atrial fibrillation. But most of those patients that don't have atrial fibrillation will get Afib in their lifetime, therefore, they're at a high risk of having a stroke. You think about the typical patient that undergoes cardiac surgery. They're 65 years old. They're going to live another 20 years. So if you can take care of their appendage and hopefully take care and reduce their stroke rate, that's the goal of the LeAAPS trial. It also expands the market quite dramatically.

And so it's the largest trial ever done in cardiac surgery. 6,500-plus patients randomized. One arm's getting a clip, the other arm is not. Non-Afib patients, with the goal of looking at these patients to reduce their stroke rate over time. Why now? We studied it in a feasibility trial. We showed a dramatic improvement in the stroke rate just at 1 year in the feasibility trial. Following up on the LAAOS data that came out last year that showed a 33% reduction in stroke on the atrial fibrillation patients, we believe that we can see some similar type benefit within this patient population over a longer period of time because obviously they don't have Afib right away. But why now is it's kind of building upon the advancement of the trial we did with LAAOS and then kind of putting it together. And we're already up and running. So we've already got 50 sites that we contacted, and hopefully we'll have our first enrollment by the end of the year.

Cecilia Furlong: When does -- what are the timelines, kind of ultimate timelines as you think about --

Michael Carrel: It's a long trial, because it's 6,500 patients and you're going to have to follow them for 5 years to look at kind of seeing where that stroke rate reduction's going to happen. So we anticipate it's probably about 8 to 9 year trial overall. So long trial, but just doing the trial obviously creates awareness and creates a discussion around this topic.

Cecilia Furlong: How do you think about, if you want to call it a halo effect, but just the benefit of awareness, growing awareness on your clip business today?

Michael Carrel: I think overall, I think it should benefit our clip business. The more you're talking about the benefits of managing the appendage, the fact that we're obviously willing to take the risk and go after a trial of this size and nature I think says a lot to our cardiac surgeons about what we believe the data's going to look like.

Cecilia Furlong: Wanted to go to your open business, legacy business, if you will. But kind of mid, high-single digit growth I think is kind of how you framed it recently. How do you think about the sustainability there and you think about just the underlying procedure trends, CABG, AVR, MVR, that growth rate, relative to how you're thinking about open and continuing to ramp a percentage of --

Michael Carrel: Well, it's interesting because COVID put us into a spot where what was happening with cardiac surgery. But basically, there's about 300,000 procedures every year. That number's relatively flat. If you actually look at from an atrial fibrillation standpoint, about 1/3 of those patients have Afib. We're still only 27% penetrated in that market, which means, do the math pretty quickly, 73% of patients that undergo cardiac surgery that have Afib are not getting treated. That's the market opportunity for EnCompass and for the growth rate in that open.

We believe our new product, EnCompass, allows us to go after those that have avoided doing this procedure because it was too complicated before. We made a product that is easy for just about any surgeon to do, and they can do it swiftly, and they can get a great ablation with it. And so that's the market that we're going after with that. And we've just started rolling that out. We already saw some great success in the first quarter. First 8 weeks, we saw great success within that. We anticipate that momentum's going to continue for many, many years to come, which is what gives us confidence to grow that 27% penetration to hopefully 50% or 75% someday.

Cecilia Furlong: A few questions. Why haven't you seen competition, do you think, in that space? So it's a market you built. And I know Medtronic a while back talked about a trial. I haven't heard a lot recently. But you have kind of this market, market opportunity to continue to grow. And then with EnCompass, too, just how you're thinking about expanding your targeting, your messaging to physicians, just with the ease of approach and being able to bring additional physicians on board.

Michael Carrel: I think that it's tough for me to know why every one of those other companies hasn't chosen to get into it. I think a lot of them made decisions around cardiac surgery where they're not as focused in the cardiac surgery arena, and therefore maybe they didn't want to make another new investment in that area. But it's tough for me to put myself into their shoes.

We were believers a long time ago. We said, hey, we believe in this space. We believe these patients need to be treated. We've got a unique solution to do it. And so our goal is to -- and if you look at almost everything that AtriCure does is we find markets where there are patients that need treatment. Others are unwilling to kind of go in there, whether it's because of investment or the difficulty to kind of get into that space. We make those investments. We invest in both the technology and new innovations. We invest in the clinical science, and then we go build the market. And that's kind of what we're -- that's what we're good at. We're doing it in open where we've kind of grown it from 10%

penetration to 27%, hopefully 75%. And we're going to do it in MIS and in the pain management space as well.

Cecilia Furlong: I know we're running out of time, but longer term outlook on AtriCure, just how you're thinking about OUS versus US mix longer term. And then also just pain management and MIS. Where do those go longer term, in your view, as a percentage of total sales?

Michael Carrel: First, on the international front, I see it growing at the same as the US rate, to some degree. US might be a little bit faster as some of these catalysts come in, but I think OUS catches up at some point. Right now we're at about 15%. I don't see that percentage changing in the, call it, short to medium term. Longer term that might, and we might have a different strategy. But right now, we're really focused on capitalizing and creating these markets in the US first and foremost, and then obviously bringing them in the international market, but maybe at a little bit more measured pace and controlled.

Relative to MIS and cryo nerve block, those are areas of our business that are going to be growing at faster than the corporate average. We've talked about we used to be a 14% to 15% CAGR. That was the growth rate that we had kind of pre-COVID. If you look at our numbers this year, we started out at 15% to 20% for the year, so we've accelerated our growth rate. With the new revised guidance, after we've raised twice, we're at 18% to 21%. And we anticipate that both cryo nerve block and MIS are going to contribute to higher than corporate average over time.

Cecilia Furlong: Last question. R&D priorities as you think about just additional areas to iterate, either clip business, MIS. What are the key near term focuses for you?

Michael Carrel: So we talked about the trials on the, call it, the technology side of things. I think you hit on both of them. I think both -- we rolled out both the new clip technologies. We just rolled out the new EnCompass clamp. So brand new clamp for the open ablation side of our business. You will see a kind of continued innovation on our clip side. We've always been an innovator in that space. We'll continue to innovate on the clip side over the next couple years. We will also have a new innovation on the cryo side of our business as well for the nerve block side. So we'll continue to kind of iterate and add there. And on the MIS side as well, we're going to make it even easier to use. So all areas of the business, we've got projects that should show something in the next couple years.

Cecilia Furlong: With that, I think we're out of time. Mike, thank you very much for --

Michael Carrel: Well, great. Thank you. Appreciate you having us.