POST EVENT - PIPER HEALTHCARE - ATRICURE

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Matthew O'Brien: All right, good morning, everybody. Thanks for joining us. My name is Matt O'Brien. I cover MedTech here at Piper. I'm really excited to have the AtriCure here with us. Mike is the CEO, Angie's the CFO of the company. Let's see. Who is that back there? All right. So, you know, Mike I'll get to the Convergent topic in a little bit, since that's all anybody seems to want to talk about. But, I'd like to start with the open business.

I know you're being conservative with your outlook for that franchise, but it seems like the EnCompass clamp, I know there's a pricing benefit you're getting from it, but it also seems like even absent that things seem to have accelerated a little bit on the open side of things. So, what are you seeing in the open business right now, because of EnCompass?

Michael Carrel: I mean we are being conservative on purpose, because it's cardiac surgery, and we just want to make sure that as you get adoption what's going to happen with it. But right now it's actually been incredibly successful. The target market for that is if you'll recall, about 73% of patients that undergo atrial fibrillation, or undergo cardiac surgery that have afib, do not get treated today.

And the good news that's come up quite a bit, but there's still that big terms - we're going after that 73% that does not get treated because the number one reason they weren't getting treated, it was complicated and due. So we made this product to make it a lot easier for that basic surgeon who doesn't do a lot of afib surgery, to basically do this very simply. And it's been working.

And we were just opening up new centers. They're not really new centers. They're new doctors within those centers that weren't doing the afib. Because what would happen is, one person in the place would do all the afib surgery, and the other four docs wouldn't do it. And so now hopefully, all of the docs are basically going to be able - going to do it because we've given them the technology that makes it a lot easier for them to do that. And that's really what's driving the growth within the open front.

And yes, we are getting some price, but as we look at kind of - we're re-looking at that business; we've exceeded our expectations. So I mean the launch has also gone better than we expected.

Matthew O'Brien: Yes.

Michael Carrel: We took our time; we trained our team very well, but it's been better than we've expected. So that's also been a part of it as well. We want to make sure that this is going to continue to be sticky, and that we can kind of build off of that growth. And we're not - it's only six months in right now from the real launch, so we just don't want to get too far ahead of ourselves.

Matthew O'Brien: What is so unique about that product versus what you were selling before?

Michael Carrel: So what we were selling before was when you'd have to get behind the heart by going, and then - and this is getting a little bit clinical, but you'd have to kind of dig out the pulmonary veins to get behind the pulmonary veins...

Matthew O'Brien: Okay.

Michael Carrel: ...to do the ablation. That is something most cardiac surgeons that are doing coronary bypass surgery, don't do. They're not normally going behind the heart to get to those veins. This allows you to go - there are actually two, kind of alleyways I'll call them, the transverse and oblique sinus...

Matthew O'Brien: Okay.

Michael Carrel: ...that - we designed it so that it could kind of slide through those without them ever having to go and kind of dig out the veins. And by going through there, they basically encompass the entire vein, thus the name of the technology was that it encompasses the whole back of the heart, without really having to dig anything out; just kind of going through those sinuses. And that's what is the trick behind it. You actually look at the device and it's a much larger device.

So the first thing somebody says is, "Wow, that's pretty big." How many - and then once they use it and they realize that they just hadn't mentally thought that they want to go behind the heart in that way. And it takes them no time. They take a 30, 40-minute procedure, they can get it done in ten minutes.

Matthew O'Brien: Wow. Okay, fFantastic. How should we think about that domestic business then going forward? Because if there are all these other clinicians that were in the facility and, you know, were familiar with you but not using, how do we

think about the growth of that franchise. I know you've said high single digits, but do you think you can stay at that rate or even more, for many years?

Michael Carrel: When we first put together the plan around it, and we're sticking to this right now, is we said this allows us to continue to grow at the high single digits. If you think about any adoption curve, you go from 0% to 27% and you've gotten all those - kind of, I don't want to call it the low-hanging fruit, but, you know, because we worked really hard to get to that point. But to get to that next level across that chasm to really get there, we felt like this was going to be important. But we don't want to - we don't want to get too far ahead and say well, this is going to enable us to grow in double-digits.

Matthew O'Brien: Yes.

Michael Carrel: But we thought - we think this could enable us to go in the high single digits for a long period of time. Now, right now you're seeing it higher than that. I mean hopefully that would be great. That would be upside though, from our standpoint.

Matthew O'Brien: Okay. When do you lap the pricing benefit that you're enjoying right now?

Angela Wirick: Middle of the second quarter.

Matthew O'Brien: Middle of the second quarter?

Angela Wirick: Of next year.

Matthew O'Brien: Okay.

Angela Wirick: Yes.

Matthew O'Brien: But is it, is it a straight cliff, Angie? Or do you - is it kind of like...

Angela Wirick: I think it will trail off as quarters go.

Matthew O'Brien: Okay.

Angela Wirick: So still, if you compare procedure price, I mean I think the big part of the pricing benefit were doctors who are using today, there's an uplift in pricing. But I still think that you're going to see the overall procedure price is going to increase over time, as you have more people adopting EnCompass clamp. That'll become a bigger part of our overall open ablation business.

Matthew O'Brien: And is that helping at all on the clip side or are some of the doctors in - also clipping off the appendage while they're in there too? Or is that something completely different?

Michael Carrel: I wouldn't say that the - the EnCompass clamp doesn't necessarily help...

Matthew O'Brien: Okay.

Michael Carrel: ...the clip because clip is being put on by a much larger percentage of our doctors already...

Matthew O'Brien: Yes.

Michael Carrel: ...today. What's helping the clip more than anything else, has been clinical data that came out from the LAAOS III trial a little bit over a year ago, that showed stroke reduction if you manage the appendage. And every afib patient

should have their appendage managed, no matter how you do it. Whether you do it with the clip or you cut and sew it. But the clip is easier than cutting and sewing it. So a lot of people have kind of moved towards doing the clip.

So the clip is being driven by one, that clinical data that was a very large study; and then also by now we're out there doing this new LEAPS trial. And the excitement behind prophylactically treating the appendage is also something that is beginning to kind of gain some traction as well.

Matthew O'Brien: So are people ready, I don't want to go down this path too far, but are - from the LEAPS study, is there already some off label prophylactic clipping?

Michael Carrel: It's not off label because our label doesn't distinguish whether you've got afib or you don't have afib.

Matthew O'Brien: Okay.

Michael Carrel: It just says if you want to manage the appendage, this is a great device to manage the appendage.

Matthew O'Brien: Okay.

Michael Carrel: What we can't say is that that will reduce stroke.

Matthew O'Brien: Right.

Michael Carrel: And so that's why we're doing the LEAPS trial is to get the stroke label so that we can actually get the stroke indication very specifically. There are definitely - I mean one of the reasons that we did the trial was that we had

several sites that had believed in it and then we did our ATLAS trial to study that.

Matthew O'Brien: Yes.

Michael Carrel: And most of those sites quite frankly, likely won't be in the trial because they're already believers.

Matthew O'Brien: Yes.

Michael Carrel: And so you've got a small segment of the clips that are sold today are being used that way.

Matthew O'Brien: Okay. Okay. So speaking of the clip business, it's just been a rock. Like it's been just a great, you know, franchise domestically and internationally. But I do think you said on the last call, you think you're about 40% penetrated, mid-40s I think?

Michael Carrel: In the afib. In the afib.

Matthew O'Brien: In the afib?

Michael Carrel: Not the prophylactic.

Matthew O'Brien: Right. So, but the mid, you know, but the prophylactic probably is years and years away from getting that indication anyway, right?

Michael Carrel: Yes.

Matthew O'Brien: So, you know, can you get to 100% penetration of the afibs? Or where does that top out? Because when you see 40 you're like, are they starting to get penetrated, fully penetrated here? Or is there still just a long runway?

Michael Carrel: I think there's a really long runway, because the LAAOS data says, and it was a 4800-patient study; it was a randomized trial in which if you managed the appendage you get a 33% reduction in the stroke rates.

Matthew O'Brien: Yes.

Michael Carrel: And that data is getting out there and being presented over and over and over again. Now the clip is one way to manage the appendage. You can cut and sew it as well. But cutting and sewing it takes a lot of time and a lot of risk for people. So they're kind of, you know, balancing that.

Matthew O'Brien: Okay. Okay.

Michael Carrel: But I still think there's...

Matthew O'Brien: There's still a long way?

Michael Carrel: I still think there's a long runway in front of us.

Matthew O'Brien: Okay. Is there anything new coming on the clip side from the company? I mean we had a couple of new products come out what was that three or four years ago now, massive accelerant in terms of adoption. Anything new that we should be thinking about?

Michael Carrel: Yes. We've got two new products. I'd say one is probably 18-months away.

Matthew O'Brien: Okay.

Michael Carrel: That's an even smaller profile clip that we're developing, to kind of go through smaller areas and just make it less invasive, and leave less behind. And then we're also, you know, looking at some other innovations probably four or five years out as well. So we've got a really rich pipeline of technology that we're basically bringing to the clip side of things.

Matthew O'Brien: Got it. Okay. Let's shift over to the pain management for a little bit. You know, the performance there is just, I think the word is remarkable, the last several quarters. What is driving all of that growth? And then it feels to me like the momentum is actually building there. Is that fair?

Michael Carrel: Well I don't want to - I mean the growth rate we've had there has been phenomenal. And they have also exceeded their expectations. So I'm not going to say we're going to commit to that kind of growth rate. But it is...

Matthew O'Brien: Yes.

Michael Carrel: It is - it's been a great launch. And the reason is it works. They see a significant reduction in pain. These patients recover more quickly. They see it in the hospital stay. They see it and many studies have been done where they're seeing some opioid reduction relative to both in hospital stay and out of hospital stay. We can't claim that yet, and so we're working on a study that basically makes some of those claims. But you definitely see that, it just works. I mean people feel a lot less pain when you use it.

That's why the adoption is there. I mean because it's - in the face of actually things that you would say would be some big headwinds against you, it's not being reimbursed or paid for, the doctor doesn't get any additional

reimbursement for it, so there's no DRG, there's no CPT code. And it takes - and it adds more time to their procedure. With all that, it works so well that they're actually continuing to implement it. So, you know, we see that there's a lot to go there.

We're going to move and not only going from thoracotomy, you know, we're 10%, 20% penetrated at this point time, and we believe that sternotomy is kind of the next place to go. And so we'll be launching that in the middle of this coming year as well.

Matthew O'Brien: Okay. I want to get to all of those points. Just quick, on the opioid side of things, what does that study look like, and how long does it take to run?

Michael Carrel: So it's a great question. That's - we've got advisory boards coming and debating that right now...

Matthew O'Brien: Okay.

Michael Carrel: ...because there are different opinions on do you just look at the opioid use within the length of stay while they're at the hospital, because it's the most controllable and the most that they can see? There are advantages to that, for ease of doing a clinical trial.

On the flip - but the benefit actually happens in the four to six weeks afterwards so that when they go home. And so we're having kind of discussions. We'll probably wind up having several trials, multicenter trials and kind of one that looks at kind of the longer and one that looks at just the in-hospital stay is what it's probably going to be.

Matthew O'Brien: Got it. Okay. And I think you've said Mike, you're in about 500 centers now, right now, with cryoSPHERE. What - I meant here are what, 5000-plus hospitals in the US? I mean where does that 500 number go over time?

Michael Carrel: It's probably closer to about - we use 1200 to 1500 that do thoracic procedures.

Matthew O'Brien: Okay.

Michael Carrel: I mean, so it's more than cardiac procedures. You definitely have more center that'll do that. But we kind of use that 1200 to 1500, and it's kind of the baseline.

Matthew O'Brien: Okay. So tons of room still? And are you seeing a lot of the growth right now from new centers you're adding, or is it just kind of a good mix between the two?

Angela Wirick: The opposite, actually, more from existing centers. New centers add to the growth rate, but they are a smaller percentage of the overall business.

Matthew O'Brien: Okay. Oh, that's great to hear.

Angela Wirick: Yes.

Matthew O'Brien: And then what about sternotomy? You know, thoracotomy is painful. Like everybody knows that. I mean like I would imagine that sternotomy is pretty painful too. So what are the steps that are required there as far as driving adoption within the sternotomy opportunity? And isn't sternotomy about 2X the size of thoracotomy? I could have those numbers wrong.

Michael Carrel: Yes. It's pretty close.

Matthew O'Brien: Okay.

Michael Carrel: There are about 150,000 or so thoracotomies and 250,000. So not quite 2X, but quite a bit higher for sure.

Matthew O'Brien: Okay.

Michael Carrel: I mean the steps by which - first is we've got to make sure we've got a safe procedure. One in which we understand you're bleeding the same nerve, so the interaction is the same. So we know all of that. We know the safety profile is the same; we know how well it's going to work from that standpoint.

We had - this was kind of I'll call it a physician-led drive into this. We had three or four sites that started to use the product during sternotomies. So what we've been doing over the last year is making sure that you can do it safely. It's repeatable when you roll it out to many more centers.

Matthew O'Brien: Okay.

Michael Carrel: That we understand what that kind of - what it looks like when they go home. And what that care pathway looks like. That's super important before we basically roll it out to everybody. And then there is - like you said, there isn't as much pain relative to - there's a lot more going on in the sternotomy than a thoracotomy.

Matthew O'Brien: Okay.

Michael Carrel: And so, there's not going to be that instant oh my goodness, like I've saved that much pain, but there is a lot of pain with sternotomies. And so those that are using it absolutely believe in it and think that their patients are recovery much more quickly and have a much better hospital stay.

Matthew O'Brien: Okay. Got it. Is there a - the possibility of getting extra reimbursement for this, or getting the doctor paid a little bit more for that? Is that something you could work on or potentially get over the next couple of years?

Angela Wirick: I mean that would be ideal, but I think that that's a long way out; not something that we can count on.

Matthew O'Brien: Okay.

Angela Wirick: Yes.

Matthew O'Brien: Okay. Another thing I hear a lot about the pain management business from people like me that have never run a company, is that oh, there's nothing unique about the product. Anybody else could do this. You know, so first of all, is it - are you aware of anybody working on something here? And then secondly, if somebody were to start today, how long would it take them to come out with a viable product?

Michael Carrel: Well, the question from a uniqueness standpoint - so there are some companies that have some cryo analgesia capabilities over...

Matthew O'Brien: Yes.

Michael Carrel: ...in Europe. There is one or two companies very small, small, small companies that have some - that we've talked to, looked at. They're trying to

kind of approach it from maybe a different way, maybe do it more percutaneous and we're not sure what the results are going to necessarily be with that. The barrier is actually I think a little bit bigger than most people imagine.

They say okay, nitrous oxide is easy. Sure. How many people have nitrous oxide devices that they basically have made a purpose-built product for that they've tested; they've tested the safety of it; they've tested basically how you bring that to market? I don't know of any. I mean so there's no - so should - could somebody do it, sure.

We had an inherent advantage in the sense that we already had our systems placed in all of these hospitals. So most of the systems that are being used today, were systems that were already there, because cryo - the same cryo is being used in cardiac cases.

And now we're building out that inventory, but we didn't have to just go rush out and try to get into 500 sites overnight. We didn't just go ship 500 cryo boxes that had a real cost to them...

Matthew O'Brien: Yes.

Michael Carrel: ...relative to that. They could leverage what they had before. So I think it'd be a - it's, I mean could somebody get into it? Sure. I don't want to say that it's impossible. But there are definitely barriers to entry.

Matthew O'Brien: How long do you think it would take, Mike? Is it two years?

Michael Carrel: Much more than that...

Matthew O'Brien: Okay.

Michael Carrel: ...to have any kind of significant impact there?

Matthew O'Brien: Yes. I don't disagree. I just - I hear it a lot and...

Michael Carrel: I guess, you know, I'd almost ask, if I were sitting across - what products are - what's so easy about it and why do they think it's that easy?

Matthew O'Brien: Yes.

Michael Carrel: Like to enter into this space.

Matthew O'Brien: That's a fair question. But again, it's people that don't run companies. So that's why it comes up. All right. So let's hop into conversion, which is, you know, a topic that gets a lot of attention, obviously. But how much of the Convergent growth is just conversion from the legacy procedures moving to that approach, versus - because I've heard that from some people and I'm not sure I fully understand it. But is there some of that that goes on that we're like oh, okay, we're going to do the legacy first?

Michael Carrel: Zero percent.

Matthew O'Brien: So there is no conversion factor?

Michael Carrel: There is none.

Matthew O'Brien: So when we hear this like 12% growth, that's Convergent growth?

Michael Carrel: That's convergent.

Matthew O'Brien: Nothing else that's - okay.

Michael Carrel: That's new centers; new...

Matthew O'Brien: That's a pure number?

Michael Carrel: Pure number.

Matthew O'Brien: Okay. Okay.

Michael Carrel: People that are in the legacy business just to explain it quickly, is...

Matthew O'Brien: Yes.

Michael Carrel: ...those that were doing our legacy business, that is a surgeon-led procedure. And these are surgeons that are driving and literally going out and finding afib patients that have advanced afib. And they've become experts in that. And it's kind of they're trying to do the (COX maze) and they're trying to do it through kind of ports. And it's an incredibly effective procedure, but it's really driven by the surgeon and those hospitals are driven in that way. And it's a very...

Matthew O'Brien: Okay.

Michael Carrel: ...small number of sites. They are big advocates for that. They are not necessarily advocates for Convergent. They wouldn't believe in the Convergent approach, even more so than an EP. EPs believe in the Convergent approach, but those kinds of diehard surgeons are not. So it's a

very different profile, so they're not going to switch over. That's why you know...

Matthew O'Brien: Surgeons want more of a (COX maze) approach than they do...

Michael Carrel: Those particular ones. It's a very small group that is - that has that real focus on that, that have been doing this for ten years. They've got really good results with it in their hands. The problem is, is we knew. And one of the reasons we went out and did Convergent was technically that was very difficult to train the other 950 sites around the country because there just aren't that many sites that can actually accomplish and do what our TT procedure does.

Matthew O'Brien: Okay. Super helpful. Among the centers that have been doing Convergent for a couple of years, what kind of growth are you seeing among those centers?

Angela Wirick: It's been mixed. And that's been part of the - I think part of the findings that we're having. So we've seen and you heard two EPs we highlighted on our KOL call a couple of months ago, those two centers have had extremely good growth, I mean excellent growth. If you were only looking at their growth numbers, the street, everybody would be ecstatic. But we've seen as some other accounts, and I think this is where, you know, we've seen a bit of a mix.

We've had other accounts who came on, started doing the procedure, were early adopters post label, post COVID. Then COVID hits, again we saw a big surge in the first quarter. And that delayed them continuing to ramp. They may have stepped away from the procedure. It's very difficult in terms of the - we talked a lot about logistics, you know, coordinating the different

procedures. And I think, you know, if you're in a hospital facility it's much easier to do the things that are easier to do.

This is kind of what we've known what to do. And I think that's where we've seen a bit of a mix of some accounts who may have stayed steady or may have dropped off a bit.

Matthew O'Brien: Okay.

Michael Carrel: And you asked a question I think you - or maybe it was in your questions, about our perspective on kind of TAVR versus what you're seeing in the other afib space. I think that was in one of the...

Matthew O'Brien: Well, it just, you know...

Michael Carrel: This is very analogous.

Matthew O'Brien: Okay.

Michael Carrel: Because what's happened is that we're starting these new programs and it's coordinated care. And coming out of Omicron you definitely see coordinated care things falling a little bit lower. And so we're trying to get them back up and excited. So they're not saying we don't like the procedure. It's timing to get them back and get them reengaged because they do believe in it, but they didn't do enough and didn't have enough flow before Omicron hit, for it to be sticky at the time, in terms of as a program. Not as a procedure, but as a program.

And we're reengaging going back into those sites. Those sites that actually had some momentum, they've seen great growth.

Angela Wirick: Yes.

Michael Carrel: So that - which is like the UCLAs of the world.

Matthew O'Brien: Yes.

Michael Carrel: They had enough traction; they were doing well; they were seeing the patient outcomes already; they'd been doing it for long enough. That's where - those have continued. It's those other ones that have fallen off that were kind of reengaging getting back going. And they...

Matthew O'Brien: Can they...

Michael Carrel: TAVR's a good analogy to it...

Matthew O'Brien: Yes.

Michael Carrel: ...because I saw that in your questions. And I think it's really analogous.

Matthew O'Brien: Okay. Can you get those other center up and going again soon? Like staffing and nursing is a huge issue still, and actually getting worse. So is it going to continue to be a massive headwind or are they going to start coming around do you think, a little bit more, in '23?

Michael Carrel: I think we anticipate that we're going to see - we're continuing to see progress within those accounts.

Matthew O'Brien: Okay.

Michael Carrel: And so the difference in TAVR, this is where it's not analogous, is we've got to get centers up and running, like to be new centers. And so I think that for us, we're starting to see some of that kind of come together. I imagine 2023 is going to be - it's not going to be the hockey stick year. I mean that's not going to happen. But I do anticipate that we'll see growth out of this in 2023. And I think that long term this is going to still be an incredible growth driver for us.

Matthew O'Brien: Okay. You know, where that growth is coming from next year, existing centers or new centers? Is it really those ones that you kind of had, you know, on the hook and they were just starting to build? Or what should we expect, you know, in terms of new center adds next year?

Michael Carrel: I'll call it, it's going to come from centers that in 2022 maybe didn't do a procedure, but they did some in 2021.

Matthew O'Brien: Yes.

Michael Carrel: And that we anticipate that they're going to kind of come back online and get to become real programs.

Matthew O'Brien: Okay.

Michael Carrel: So is that an existing center? I'd say that's probably a - we call them new centers...

Matthew O'Brien: Yes.

Michael Carrel: ...or reengaged centers, internally.

Matthew O'Brien: Okay. And Mike, you said you were going to give us some more information on like, you know, center numbers and just more details. When are we going to get some of that information?

Michael Carrel: I think we want to make sure we've got the right level of consistency so that the information is meaningful. Because we're still learning about this coming out of Omicron and how we're getting this up and running. I want to make sure that what we're giving you is going to be something that you guys can model on. I don't want to give information and you guys model and be like well wait, you gave us that information.

We want to make sure that we're giving you information that is kind of repeatable, that we can count on. That's why we haven't given that information yet because we're still in that learning mode.

Matthew O'Brien: Okay. Okay. That makes sense. What about PFA? How does PFA fit into this entire, you know, continuum of care in your opinion, going forward?

Michael Carrel: And PFA is an exciting technology. I look at it very similar to how you look at a cryo balloon or an RF device that does a really good job with the pulmonary veins. And I think it's - that's really what the target market is. If you look at the clinical trials that are being done on that, were complimentary to that.

And even if they try to do some of the back wall ablation, like that's kind of - people say well, you can do the back wall ablation with PFA. I think what we'll wind up seeing is that the Epi/Endo approach that we have, whether it's PFA, cryo, or RF, is still going to have a much more durable kind of long term effect.

So for us, we look at it as very complimentary; no different than we look at a cryo device or a RF device. Obviously, if you were a catheter company and you had the cryo and the RF device, you may have a different perspective on it, because it's...

Matthew O'Brien: Yes.

Michael Carrel: ...competitive from that standpoint, which I think is why they're all trying to get into that space. Now there are still a lot of questions about it though. I mean I think that you're probably hearing a lot of questions about how effective is it; you know, how safe is it? Everybody knows that it's incredibly fast. So I think there are a lot of learnings that have to happen over the course of the next several years, as these trial data come out, to kind of figure out exactly how it's going to be utilized.

Matthew O'Brien: And do you think it will ever slow down the progression of the disease from paroxysmal all the way to longstanding persistent?

Michael Carrel: Possibly. But I think there's somewhat - that's a theoretical conversation as opposed to a scientific one at this point. And so...

Matthew O'Brien: Isn't it fair that it's a 2040 question or 2050 question versus a...

((Crosstalk))

Matthew O'Brien: Okay. Because it's in something else here as well. Let's talk about IST real quick.

Michael Carrel: Okay.

Matthew O'Brien: You're making good progress there. The only thing that we've heard about the, on the negative side, is that the patient population is difficult to really identify and that some clinicians may not, you know, really funnel them to surgery. So talk about what you're doing in IST, that patient population, and then that feedback that we've gotten from just a couple of folks.

Michael Carrel: I think it's for feedback. I think everybody's trying to learn that there are a lot of these patients. So if - when you kind of Google how many patients at IST they say it's 1.2% of the population. Well, that's a lot of people.

Matthew O'Brien: That's a ton of people. Yes.

Michael Carrel: Right? But to your point, where are they and where do they sit today? Are they sitting in with the referring? Are they sitting in with the EP, the cardiologist? Where do those patients sit today?

And so I think we're going to learn a lot. For us there is a lot of real good benefit to getting into the IST-1. First and foremost, it's a patient population that has no options today. So this is going to be the first time that they've had that option.

Once we get that label and that data, and show that you've now got a real viable option to continue your life, we think that's going to make a big difference in this patient population. And I think they're going to start coming out at that point.

So there is a lot of marketing we're going to have to do once we get that label that we can't do today, that we think is going to help draw that patient out because people are suffering with this disease today.

The second piece is that it also enables us to have another procedure by which the EP and surgeon need to work together. And so the EPs do not have an option for this. The catheter does not work, it does not attack.

The areas cannot get to where the cardiac surgeon can get to, but the cardiac surgeon can't do the work without the mapping, to see where they must ablate. And so the two together is so powerful, and that is helpful to our other hybrid business too. So we win on both fronts.

One is as a great disease state that we're going to help out here; and two, is it can help build our overall hybrid business and build that collaboration between the partners, the EP and the surgeon.

Matthew O'Brien: Okay. Okay. So...

Michael Carrel: I don't know if that helps answer the question you were looking for.

Matthew O'Brien: For sure. No, that's - I mean it seems like a good opportunity there. Some work to be done. But that's - what else is new in this space? Okay.

And then I guess the last minute here or so, Angie, just on the financial side of things, you know, you're making great progress on the EBITDA side. How do we think about that metric going forward? I know you guys - there's just a lot to invest in at this company.

Angela Wirick: Yes.

Matthew O'Brien: So how do we think about that metric over the next several years?

Angela Wirick: Yes. I think we've said - we haven't given a date when we'll hit profitability, but we've said pretty naturally, it will come in the near term. When you think about historically the progression that we've made on the bottom line, have made great strides I think, you know, take M&A activity aside. We were there, pretty close a couple of years ago. And we're investing in great growth drivers who continue to invest.

That's - I mean I think about it in the context of there is a lot of great untapped markets that we're still going after. So we'll continue to invest. I think we're to the point where pretty naturally you'll start to see the leverage within the P&L, and then benefit the bottom line.

Matthew O'Brien: Okay. And is there any kind of quarterly revenue number or, you know, annual number that you would point us to at all, at this point?

Angela Wirick: No.

Matthew O'Brien: Or...

Angela Wirick: Not at this point.

Matthew O'Brien: Okay. Is it - I guess another last, I guess we're out of time, like outside of the - of what we've seen from other MedTech companies, you're not disproportionately - you don't have to be disproportionately higher from a revenue perspective to get the profitability.

Angela Wirick: Correct.

Matthew O'Brien: Okay.

Angela Wirick: Yes.

Matthew O'Brien: Okay. All right. I think we're all out of time, so we'll wrap it up there. Mike, Angie, I really appreciate all the commentary.

Michael Carrel: Okay, thanks Matt.

Angela Wirick: Okay. Thanks for having us.

Michael Carrel: I appreciate it.

Matthew O'Brien: Yes. Thanks.

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