REFINITIV STREETEVENTS

EDITED TRANSCRIPT

TMCI.OQ - Treace Medical Concepts Inc To Host Surgeon Advisor Event Call

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PRESENTATION

John T. Treace - *Treace Medical Concepts, Inc. - CEO, Founder & Director*

Hello, everybody. Good morning. Thanks for joining us today at our Treace Medical Advisor Event. It's the only company in the med tech industry solely focused on the surgical management of bunions and bunion-related pathologies. It's pretty exciting to have the opportunity to get together like this and take a deeper dive into the unique technologies and clinical data sets that are driving the rapid growth of our business.

We hope today's program will allow you to gain an even better understanding of our disruptive Lapiplasty procedure. As well as the ALIGN3D clinical study and other clinical study data sets we have supporting it. We also hope to provide you a better understanding of the Adductoplasty procedure. The clinical pathology it's targeting, how it interrelates with Lapiplasty and the impact it's making with doctors and their patients.

Finally, we'd like to give you an early preview of some of the newest exciting technologies, those that will continue to drive our growth and differentiation of the business for 2023 and beyond as we continue to penetrate this $5 billion US market opportunity. We have a great team of surgeons assembled today for you. The 5 surgeons that are here have all been actively involved in the design of Treace's products and procedures for several years, some of them since the inception of the company actually. And cumulatively, they represent thousands of Lapiplasty patients treated.

For today's event, we'll have talks by Dr. Paul Dayton from Ankeny Iowa; Dr. Robert Santrock from Columbus, Ohio; and Dr. Will DeCarbo from Pittsburgh; and Dr. Jody McAleer from Jefferson City, Missouri. We're also really fortunate to have Dr. Mark Easley with us. Dr. Easley is the Chief of the Foot and Ankle Division at Duke Medical Center. And he's going to be here to share his perspectives and insights and help moderate the session.

So finally, I wanted to direct you to our forward-looking statements in our filings and on our website. And again, thanks, everybody, for joining us today. And with that, I think we'll kick it off with Dr. Dayton.

Paul Dayton

All right. Well, thank you, John. And I'm super excited to be here. My task this morning is to go through the background, the clinical motivation and the philosophy behind Lapiplasty. And so Lapiplasty is not just an incremental improvement in bunion surgery. It's actually a complete redesign of the way we approach a bunion, both anatomically and surgically.

So -- this is not just an improvement on what's been done for the past 50 years. 10 years ago, we recognized that there was a huge problem with bunion surgery and a big issue with the outcomes from bunion surgery. And instead of trying to just build on what's been done, we actually went back to the beginning to try to understand the anatomy better. And we really came upon a huge realization that the way we approach bunion surgery is just -- it was incorrect. There's no other way to say it. That's my own personal journey with that.

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So to understand the bunion, you first need to understand that a bunion is not just a cosmetic bump. A bunion is a structural deformity. So it's a structural bone deformity. So what you see and what the patient sees is a bump, but that's not a growth. And that's important when we talk about the previous philosophy and the new philosophy of Lapiplasty because we were all trained to treat this as a bump. The patient sees it as a bump, can't you just shave my bump off doc and make it better. But it's not a bump. It's actually a structural deformity. And if you look here at the x-ray, the first metatarsal which is this bone, there's 5 metatarsals, they should all be parallel.

The first metatarsal is moving away from the others. And as it does that, it also turns -- and these 2 little bones are getting pushed out to the side there, just like your kneecap, they're connected to a tendon, they pull your toe over. So I want you to keep this picture in mind because it's very important to the understanding of where we went wrong with bunion surgery. You can't just shave the bump because there's not really any abnormal bone there, it's just out of position.

And so this, I think, explains it. This is actually a picture or 2 pictures that we use to educate our patients in the office on bunion surgery. So in normal foot the first metatarsal is parallel to the second sesamoid bones, again, like your kneecaps, they're on the bottom of the joint, are centered under the joint and the toe is straight and everything works appropriately. A bunion metatarsal is moving over the first metatarsal, the sesamoids are deviated, tendons are pulling the toe over. So that's a bunion deformity.

I don't know how we went down the path that this is a bump that can be shaved. It is absolutely not a cosmetic problem. It's a structural deformity. It causes pain. Our patients that come to us for treatment are coming to us because they can no longer go for a run because it hurts. They're coming to us because they can't walk for exercise or they hurt at work. It's not a shoe problem.

Now in some people, it may just be a shoe problem that they want to wear a fancy shoe. But I can tell you, in my practice, which is 85% bunion surgery at this point, our patients are coming because they hurt and they have a structural deformity and they need and they want to have it fixed. And if we don't fix it, then it kind of sets in motion of -- chain of events where they end up with arthritis and other associated problems.

So -- what we found when we tried to unlearn what we were trained in my group, we said we just have unlearned what we were trained. We have to look someplace else. What we found was that like every deformity in the body, a bunion is 3-dimensional, meaning that metatarsal is not just moving over. It's moving over, it's turning and it's actually going up.

So there's 3 planes of the deformity, and that understanding or realization has never -- prior to 10 years ago, was really never talked about in bunion surgery, the idea of frontal plane rotation was first published in 1956, and there was not another paper in the foot and ankle literature until 1980 that even talked about that. And that article was ignored as well. And it wasn't until the mid-2000s that this even became something that we talked about. So that's why I say this is a new paradigm because this isn't the way we were all trained to think. We were all trained to think in these terms. So this is osteotomy. Osteotomy just means cutting and shifting a bone or cutting and moving a bone.

And again, this is part of our education for patients, but this is point yet. This is the deformity that I showed you how can we possibly fix that by just cutting the bone and shifting it over. That is not normal anatomy. And so Lapiplasty or 3-plane correction is aimed at functional and anatomic restoration put everything back where it should be, and that's what it shows in this animation here.

So -- when you look at the literature, this is almost hard to swallow. Why do we keep doing a procedure that has published long-term complication in recurrence rates anywhere between 25% and 75%. I mean you look at that somebody that's not in the foot and ankle world would look at these corrections. And if I show these to my patients, they don't understand this. This doesn't look like normal. Why do we do this? Why do we keep doing it? Well, we keep doing it, because it's ingrained in our teaching. It's our current paradigm. So again, normal and what we realize that is that if you look at this as a normal metatarsal just moved out of position, then this makes no sense at all, even though this is the most common way to fix a bunion, but this is not restoration of normal anatomy.

And it happens a lot that we see. There's thousands and hundreds of thousands of these operations done every year, basically not restoring normal anatomy and, in my opinion, distorting the anatomy. And so -- when we -- I was fortunate to be invited to a group in 2014 organized by John to take a look at foot and ankle surgery and find out, hey, what are the problems in foot and ankle surgery, and there is a bunch of engineers and

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business folks and I think there was 6 surgeons or 5? 5 surgeons. We all had ideas of things that we can improve, but the one thing that all 5 of us agreed with was we hated bunion surgery because it didn't work. And that was universal, right, Bob? I mean, universal.

And at that time, this idea of metatarsal osteotomy represented 75% of the corrections done in the United States. Surgeons were following traditions. They were just doing as we all did what they were trained to do, what they were taught. We didn't have a different idea. We didn't have a new concept. At the same time, if you talk to any foot and ankle surgeon, they will tell you that bunion or patients with bunions are scared to death of surgery because it has a terrible reputation. They all have an aunt or a grandma or a sister or a friend that's had bunion surgery and it went wrong. And that's a problem. That tells us right there that there's a problem with this thought process of osteotomy.

Really, the idea of frontal plane rotation didn't even exist. The surgeons in the room can tell you that none of us were exposed to this in residency or in school. This really didn't even exist on the foot and ankle scene this thought that it was a 3-dimensional deformity. No one was producing a 3D correction option commercially, so instrumentation to be able to take a complicated procedure and make it better. No one had ever heard of our awesome plating system, and I could talk to you for hours and hours about why we do this plating this way and how good that is from a natural healing perspective, but this was not even on the radar screen.

And really, there was not any innovation in the bunion space. It was just trying to incrementally improve the issue. And as we know, most good discoveries come from completely reengineering the thought process, not just incremental improvements. And so Lapiplasty, again, isn't just a different bunion procedure. It's literally a different way to look at the problem. And all of these things are the tenets of our procedure. We're stabilizing the joint that caused the bunion to begin with. We're moving that metatarsal back to its normal position. And all of this leads to as close to a normal function of a patient as we can get with bunion surgery, and we have a lot of literature now to show that in the key. And as the one or one of the docs that have done free hand corrections, I was doing freehand, 3-dimensional corrections of bunions for 4 to 5 years before I met John I'm never going back to freehand. It's complicated. It's not reliable. It's not consistent and the instrumentation provides that platform to train surgeons to do this operation perfectly every time.

And so it was kind of a bold thought process. So nobody is doing this. Nobody understands that nobody's ever heard about it. And, hey, John, can you start a company and let's do this. It was a bold statement. I would say I think we're right. I think our original thought process that patients shouldn't fear bunion surgery, we should be able to fix this. It should be reliable like total knee replacement or any other orthopedic operation that has excellent long-term outcomes.

And if we can do this -- and if our goal is to help both the patient and the surgeon, then we're going to win. There's just no question. If we can figure this out, we can help both patients and the surgeon, we're going to win, and we're going to be able to be successful at this. And so I'm going to introduce you to a couple of my patients because, again, you hear of a bunion here like, oh my god just a bunion or a bump on somebody's foot. No big deal. How can this be a big issue?

Well, this is not her real name because I can't say her real name, but I'm going to call or Katy. So this, you can see the x-ray was in 2012. So this was pre-Lapiplasty, but this was in the early stages of understanding 3-dimensional correction. 17-year-old girl, cross-country runner, had a bunion. It was hurting when she was running so she went in and had it corrected. She had a traditional osteotomy. And when she came to me 6 months later, she could no longer run because she was in so much pain from that misaligned joint, she wanted her bunion back. Her parents are like, can you just give her bunion back, at least she could run. And that's a pointing story, but that's not an isolated case.

I see these patients literally every day in my office. I get 1 or 2 or 3 patients with these outcomes that they can't function. They would rather have their bunion back. This is a 25-year-old lady who had an osteotomy and no longer could go to the gym and exercise comfortably. She was doing it, but it was worse than it was with the bunion.

The center one is a traditional Lapidus. This is a 45-year old lady that had gained 45 pounds after her bunionectomy because she could no longer work out. She has a non-healed fusion site terribly distorted, painful.

One on the right, 17-year-old girl, Marching Band and Show Choir aficionado. And she had this operation. She was in so much pain afterwards. She couldn't do her normal daily activities. So -- it's not just a bunion. It's a real issue and it's a real patient issue.

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So why do we keep doing this? Well, it's like many things. When you have a paradigm, this is the way we were trained, we're selecting the operation because that's what we're told to do. And sometimes even if the basic reasoning is flawed, that's what we have. We don't have another concept. We don't have another idea. That's what Lapiplasty is. It's a new idea and a different idea. And we -- and I did this, and I hate to even say it, but I learned to live with the short company -- shortcomings before we figured out a better way. I got good at, I don't know, lying to myself and kind of -- live until my patient says, "Well, this is what bunion surgery is."

But if we can have a compelling story to tell surgeons and all of us in this room tell the story on a weekly basis to groups of surgeons, they embrace it because now we have an option and this nice lady here, she had a bunion operation, a traditional one. I actually just operated on her yesterday, I had to revise this, which was it's a big deal to revise this after the anatomy is distorted, but our experience with revision using the Lapiplasty thought process is actually pretty exciting.

And so this doesn't need to happen. This is Katy again. This is her other side. We did a 3 plane correction. You can see very nice correction. They were super happy with it. And luckily, we could use the Lapiplasty platform and thought process 3 plane correction to actually fix the side that was distorted. So very, very important. So patients really deserve this and surgeons want this, believe me, patients want this. They come in asking for this. If I show them those osteotomy pictures, and I show them this, which is our average result, -- there's no -- there's not even a discussion from there. They -- this is what they want. And it's really, really exciting. I'll tell you a story. So we -- again, we do these surgeon trainings and we'll have anywhere from a small group of 10 surgeons to sometimes over 100 surgeons.

And it's so fun because we've all been told that there's this new innovation or new product or revelation and it's never really that inspirational. It's never really that innovative when we go, but this is so innovative. It is inspiring to surgeons. So we'll have surgeons that come in, and I love these. They kind of have a chip on their should -- they're like, "Yes, this is just another industry, whatever. I do bunion surgery, I do great. And they take the 8-hour -- well, it's not 8 hours, it's about a 6-hour course, including cadaver training. They literally are so excited when they leave. They just want to keep talking about this new concept, and it's really -- I mean, for all of us, it's really pointing and it's one of the most fun parts of it. And so Lapiplasty correction is designed to produce normal alignment, which we feel then will lead the patient to normal function.

And so this is what I expect to see. We do in the neighborhood of 200 corrections a year in our practice, and this is what we expect to see on average. And that's a win for patients and for the surgeon. So just a little bit about the instrumentation. Again, 3-plane correction, it's a very complicated procedure. Bunion surgery is not easy. It's a very complicated issue. Having instrumentation number one, to be able to correct the deformity, perform very precise cuts and then hold everything in place in a fixation platform where the patients can walk early is -- it's worth its weight in gold to a surgeon because this makes my life so much easier. If my patients do well and they're happy, that's a good day for me. When they're not doing well, it's a very bad day in the office.

And so having this instrumentation really helps. And so I have to show this video. This is how we do the correction. And still, after 1,000 cases, this is magical to me. This instrumentation looks very simple. I promise you it's not -- the thought process behind this is incredibly powerful to be able to restore the anatomy. So you can see the deformity correct before your eyes.

Now there's other companies out there that have 3-plane systems that have kind of come into existence. Ask one of them to show you their correction. It's not. It's free hand correction where they just try to hold it together. It's just my opinion. I'm a little opinionated on that. But if you look at what's happening on x-ray, we are literally correcting the entire deformity using this instrumentation in a very specific 10-step method, putting everything back in place. It changes a foot and ankle surgeon's life, I promise you.

So we're having a big impact right now. It's super exciting to see the growth, the acceptance of surgeons. But it didn't just come from a product. It came from an incredible commitment to research, education of both providers and patients along with the product development. And we said this from the first meeting almost. Just because everybody else is doing it that way. Why do we have to do it that way.

And I am so thankful to Treace the investment that they've made in research and education, which is what I'm going to talk about now, because a lot of bunion products will tout that they're better in some way or another, but I would ask them for their literature because we have a lot of literature now over the past 10 years looking at 3-plane correction, results, function and everything associated with it.

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And I'm not going to belabor this, but this is one of our early study's design surgeon group where we did a multicenter study and even we were surprised at the results. And when you look at 97% maintained correction, this is nothing like what we're used to in normal bunion surgery, early weight bearing, average back on their foot at 10 days.

And the Lapidus procedure typically is casted for 8 weeks and on crutches. This is completely different than the way we saw it previously. And even more exciting, we're in year 3 now of a prospective multicenter national study looking at the outcomes of 3-plane correction through the Lapiplasty platform, and the data set that we have here today is a 2-year interim report. So 159 patients had met that criteria during this look back, and you can see the cohort of patients.

I wanted to show this because it's really pointing it. So we do the procedure, and they're back in a running shoe on average at 46 days. So right here is where I would have gotten my patient out of a cast and off crutches with traditional Lapidus procedure. so they're in running shoes before we would even had them out of a cast.

And I can promise you that early active recovery, moving the foot, using the foot, walking on the foot is one of the most important things for healing and that's one of our tenets with lapiplasty is we want our patients to get back quickly because soft tissue bone and healing occurs better. And you can see return to full activity in that 4-month category, and that includes starting to run again and doing normal activities.

If you look at the literature and compare this, I think you'll find a striking difference. Even more exciting, looking at correction, you can see all of the parameters that we love to measure as bunion surgeons, got better and stayed better to the 2-year point and then also to the 3-year point, which we're now in year 3. So that's a huge win. If we were to look at the traditional bunion surgery, we would see those lines go up as the deformities recur.

Taking it a step further and probably arguably more important is how do the patients feel. How do they do? You can see all of the pain parameters improved. All of the functional parameters improved and were maintained. And actually, you could argue, I'm not a statistician, but -- and I don't know if that's statistically significant, we'll know when we get to the end of the study, but they continue to improve over time as these patients are active.

And the PROMIS score, which is another patient reported outcome, we're asking the patients through a validated system, how are you doing? What are you doing? How are you feeling? And everything that was bad before the surgery got better and was maintained. And even things like anxiety and depression, and this is just being funny in a joke, but we're the only bunion procedure that treats anxiety and depression because it got better across the board. That's not true. That's just -- those are questions that are within the PROMIS score that are asked. But it shows how the patients are doing overall, holistically, how are they doing and getting back to activity.

Complications very low, you guys, I'm sure, will have access to this information, so I'm not going to belabor it. With any procedure, there's going to be complications, sometimes hardware needs to come out. Sometimes hardware is uncomfortable in my practice, our hardware removal rate because of the design of the implants and the way they work and the way they fit, it's extremely low. I would argue, again, in my practice, lower than anything else I've used. And very, very low recurrence rate.

So again, very strikingly different than traditional bunion surgery. And this is just a summary of what I've already gone through. So -- what's our why? So I come to New York. I'm in Times Square. I have to invoke Simon Sinek right, because everybody in business knows Simon Sinek. So our why we want to give our patients a truly effective procedure. That's a great day for me because it's a great day for our patients. And all of these things will do that. And hey, if we can provide the surgeons with a platform to do this consistently, average case like this result, then everybody wins. And if you're a company and you have that why, I'm not a company guy. I'm just a consultant and an idea guy, but I think that's a win. It's all I got for you.

I think we'll have time for questions at the end. But I think we wanted to just kind of move along correct?

All right. Dr. Santrock.

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Robert Santrock

That's a very good introduction. And still to the power of this is I can't emphasize enough that Paul is exactly right. When we met the first time in 2014, I had the same sentiment. My exact goal when I showed up at John Treace's first invitation was the talk amount of bunion surgery as a concept for his platform for this company. And the reason why, I just hated it so much, but now I've converted my entire practice to bunion surgery. So I never thought I would be a bunion surgeon, but here I am, and I'm very proud of it.

And so my job and my task is to talk to you about how Treace continues to evolve and how that continues to meet the market for the patient as well as for the surgeon. My job is to introduce you to the Mini-Incision and what it does. The Mini-Incision is just taking Lapiplasty and shrinking down the incision, you say, "Well, what's the goal of that? Is that to compete with other mini-incision systems or is it really something else.

And I will tell you that in our design, this was something else, we do not want Lapiplasty to be compromised in any way. You saw our results they are superior to anyone else's results that, in my opinion, and I don't believe we've had a consistent amount of results showing that ever before the development of Lapiplasty. So first goal, Lapiplasty cannot change from its tenets and its platform.

And why would we want to make the incision smaller is to maybe add to it and make it better. In this case, in my opinion, I can maybe make my surgery faster, less incisions to close and I can make my recovery faster, too, because maybe I'm disrupting less tissue and making the patients recover in an expedited way. So the Mini-Incision had those goals. And some of the first things we did was develop some instrumentation that would fit into a smaller incision, relatively straightforward, right? And the 3-n-1 guide was also one of the very major things, which takes 3 steps and move them into one. So I'm already shrinking the time now by doing these. So a smaller incision, less to close, less steps right away.

So let me give you a background about MIS. You'll hear about this a lot in the market. MIS is really truthfully standing for minimally invasive surgery. And one thing to keep in mind is all surgeries are minimally invasive, meaning we do all of our surgeries with the minimum incisions we have to, to get the job done. But then you'll hear the marketing term that they're essentially trying to imply that their incisions are smaller than a competition or a smart in the beginning of the development of the procedure.

And that's all true, but that doesn't necessarily mean that it accomplishes something better. Many orthopedic procedures are naturally progressed to smaller incisions. Let's take, for example, the rotator cuff surgery. Rotator cuff surgery when I went through training was an open procedure, meaning you made a standard 4, 5-inch incision and opened up supposed the entire rotator cuff and repaired it directly. Moved it on to a Mini-Incision where it was half that incision.

And then today, almost all sort of rotator cuff surgeries are done through arthroscopic measures or through cameras in the joint. So that's a natural evolution over time that all surgeries start to do. And today, we have hips that are done through incisions that are half the size they once were a hip replacement surgery, so to speak. So this is what we're talking about when we get to MIS surgery.

So Lapiplasty has a Mini-Incision approach. And we call it Mini-Incision very specifically because we want people to understand. It's a smaller incision than when we started, and that becomes important in this market, right? Because we have people that are touting that they're MIS surgery, bunion surgeries out there. But the demand isn't really that people come in asking for a small incision. The demand is they come in and saying, "My foot hurts and I need to get back to work. And so we are, as a set of goal, are try to have an approach to our development of technique as well as technology to get the patient back to work faster, have a better recovery and without compromising anything to do with the principles of Lapiplasty, and that was our goal.

So today, a Mini-Incision is taking it down to a 3.5 centimeter, that's an 1.5 inch or so incision. And that's a giant leap, I believe, just for any kind of foot surgery to get to that small and we're very happy about that traditional Lapidus, you hear in the term Lapidus surgery. That was the root surgery in 1934. That was 10 centimeters or so. And then lapiplasty, about 7 centimeters and now we're at 3.5 centimeters.

And we've been able to do this without compromising our steps and without compromising our results so far. So that is -- when you look at surgeons around the country, they're very interested in this because there is a huge amount of buzz about minimally invasive surgery. But -- but essentially, that's always there in all orthopedic and podiatry surgery.

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So Lapiplasty Mini-Incision goal, as I said, is to take the foot from an abnormal position to make it normal. Well, when you look at the MIS osteotomy that was -- that's popularized today, it distorts the anatomy. So it takes the foot, it does not move it any closer to that normal foot. It actually distorts the anatomy and has to because they want to use protocols to do so. So this compromises the anatomic structure of the foot, it may, one, get rid of the bump on the inner side of the foot, but it's not anatomically aligning the pathologies that are there in bunions.

And so that was the goal we absolutely said we cannot compromise and go that direction. If anything, we -- those of us involved with Lapiplasty are look at that middle picture, and we cringe. This person is not given a normal opportunity going forward. So our foot, we want to look as close to normal when we're done, and that's where the Mini-Incision was going to go.

So the Mini-Incision is part of the iterative process of Treace -- tenet that John has put to us -- John and his team has put to us from the very beginning. Whatever we do, it's not good enough tomorrow. We're going to keep developing something new. And it can't be way you might say, like the iPhone always develop something new, and you keep winning the next model. Well, we keep trying to keep our insurgents engaged by having advancing the technology to just make Lapiplasty better. And this was one of our big first steps when we made -- went from the regular standard Lapiplasty to the Mini-Incision. And that iterative process does not stop here. So whatever we have today is going -- we have something better on the dock tomorrow. And so that's the way we like to look at it.

So the new system has a few new tools in it. And -- we're going to share you with you some of those. One of those is just the instruments themselves to fit into the small incision. They're combined together to help us cut down the steps and give you a more reliable cut. And then we have the instruments that fit on the outside of the skin. So we're not penetrating every piece of instrument through the skin. And this just does not cause any other damages and helps make smaller decisions. And don't forget, the small incisions also allow for a much faster end of the surgery to close the incisions.

But also our hardware changed, and our hardware change was for -- to help give us an improvement of -- to fit inside that small incision. But also we said, "Well, that can't be enough. Again, if we want to change the hardware, there's got to be an advancement. One of the advancement was is that we're able to reach further around the bottom of the joint that we're fusing and that reach is going to be on the biomechanically advantageous side.

So again, we took the opportunity to go smaller incision, but then increase our biomechanical stability. Something that an osteotomy does not do. And osteotomy actually makes the foot biomechanically disadvantageous. It's not immediately strong, where our structure is designing every time to try to give us an advantage to expedite that recovery, secure that union rate that you saw Paul described.

So the PlantarPower plate has been an addition. It came out through the development of the Mini-Incision system. Now -- the power of that 3.5 millimeter incision is still allowing you to correct everything before you cut. So that was one thing that you didn't hear in the first thing, first talk was that one of the real difficulties of bunion surgery because it's moving bones in the traditional way where it is moving bones in an abnormal position to try to get rid of a bump.

You really couldn't see the surgery and its final position until we were putting the final stitches into the tissues. And that was a very anxiety-producing thing. You could spend a couple of hours doing a bunion correction and not know what it's going to look like until you got to the end. That is not part of the Lapiplasty system. So this is a huge comfort zone for the surgeon because we can correct all the deformity, see where the final results are going to be before we commit to damaging, cutting, changing any bone.

And this is a huge step forward. So the correct before you cut is something that's very appealing to surgeons. And this is what we feel like is one of the things that gets surgeons on board as well as get surgeons to stick with us. They've never had that comfort zone. And it's not really reproducible in the other systems out there, at least in my perception of those systems because we've patented around all that technique. We've pattened around instruments that help move the bones in the right position without cutting them first.

And that is a huge step. I had a surgeon here in New York City. I was training years ago, who I showed him this step that we can correct everything before you cut -- he literally stepped back from the table. He says, "You mean I don't have to take Xanax the night before I have a Lapidus -- and I

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was just like, yes, he's like, I'm in the whole room was enjoying that revelation because that's the feeling you had when you went into a bunion surgery.

I'm a teaching physician, so I teach residents and fellows. And I would tell my residents the night before we had a Lapidus on the dock. And it wouldn't matter if I had a total ankle, a Lapidus and a complicated fracture to fit in the foot, I would say that I'm doing the lapidus, sorry. It's the one case I can't let you do, because it took such finesse to do that freehand and you only have one shot. But now today, it's the #1 surgery that I teach in my fellowship. And then it's the one thing that I can just teach them from day 1, I could take a surgeon through, they get it and they can start reproducing the results that I get.

So after Paul says 1,000 cadavers, a 1,000 surgeries I still feel comfortable taking somebody right through it and step one. Again, a very high comfort level. It's really all about that correct before you cut in my opinion, which was the one thing that really stuck with me and it was help me teach people how to do this. Don't forget, we're still addressing it at the root cause, too. That's another comfort level.

You've heard that from Paul. We're not treating it indirectly. We're not cutting the bone and just shifting and hoping the bump goes gets less. We're really going toward the root cause of the problem is, we can just dial that right in. You can just see the foot correct right before your eyes.

There's really 4 simple steps to the surgery. You correct the deformity before you cut anything. So we're leasing the tissues, and we use our jigs and our instruments to hold things in place. It's a third hand. It's a thing -- something else that allows you just don't have. I always work with residents fellow, so I have 2 sets of hands in my surgeries. Most people do not.

But these instruments are designed to move the bones and hold them so you can look and see both under x-ray and clinically, is it right? It's a third hand. That's a very nice thing to have. Then you have precision cuts, and we heard Paul say basically, a lot say, oh, I don't need precision cuts. I can just do it freehand, well, don't do that on me. I want precision cuts, I want the lease amount of bone taken. I want the bone taken at the exact -- we precise this our cut down to the 0.5 degree angular correction. So that's how precise we are. We want to compress that means control. That's again the third hand.

And then we were going to fixate. You heard about a fixation, which is both the standard biplanar plating or 2 plates in opposite planes, so they can control the bone in a much more stable fashion. And then we also now reach further around on this biomechanically advantageous side. The way the fixation works in my brain, it's a little hard to think, I think screws are going at opposite directions. Think about spokes of a bicycle wheel, they're spanning out and they're really thin little wires. You say, how does that hold my kind of big buttock on that tire without bending? Well, all these pins are in different directions, and that's really stable and the bone never has an opportunity to twist or bend or move out of plane because you have so many things going in different directions.

In our case, it's really chiefly 2 different directions, but they're 90 degrees to one another. So that opposite placement really helps the bones to stay stable. And I think that's really what gives us a big advantage on weightbearing right away. So the Mini-Incision instruments here what we developed in these -- we can see, especially in the bottom left, where we shrunk the cut guide down. That was a big step. Now today, it's connected to the SpeedSeeker, the SpeedSeeker is now they wanted to convert to the next or iterative advancement was we went from 3 different instruments to 1 instrument to combine 2, shrunk the cut guide and then we went even further and dropped it down.

So the PlantarPower I've been mentioning a couple of times you can see where it reaches around the medial side, it fits anatomically. This is another thing that we have always kept in our DNA is anatomy, right? We are trying to make this look like the normal anatomy putting plates and screws that mirror the normal anatomy would be helpful, right? So we went from straight plates to these curved plates and you see the PlantarPower plates are U-shaped. That's designed to fit around a tendon structure and the bone shape there.

And that's really important to help not only make advantage within the biomechanics, but then they'll fit the anatomy. So it's a low profile and we get to that really low hardware removal rate that we were talking about. An anatomy has always been [anatomy]. This is our second anatomic plate. We have a third set of anatomic plate you want to hear about, I think, in the later talks about the S4A anatomy.

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So here's a clinical case. It's Dr. DeCarbo's case, showing us that he was able to take this when he was first times using the Mini-Incision system down to a 3.5-centimeter incision. There it is healed in the center at 6 weeks. And again, what else does a Mini-Incision do? It makes the swelling less, right? You're disrupting less tissues, you're making tissue swell less. So when they get to that 6-week mark, they're very ready for a shoe, and that's an important thing is the surgery people forget, the surgeon can look like a hero and be in there for 2, 1.5 hour or an hour in this case for an hour, and you look like a hero, but the healing is what takes time. And that's what keeps people out of work.

But if you can reduce that swelling time, you can reduce that time that they have to recover, put them in active shoewear instead of being in a boot for a longer or a cast, for example, for a long period of time. You put them back to work right away. And I have a patient who on average, go back to work that are nonlabor jobs at less than 2 weeks. I mean they're back to the regular job. And people have that understanding, right? I mean if you think about what time you have off and available and you need to take time off, 2 weeks is probably manageable, 2 months is not manageable. So that was an important part.

I actually -- I have said many times, my average patient is a 45-year-old female mother of 3. If I take that person out of society and I unglue society, right? I mean if I take my wife out of our family unit and make her incapacitated. My life falls apart, right? My kids' life falls apart, the mother of 3 is the unit that holds all of America together, right? She takes the kids to practice. She gets our groceries. She has a job of her own. And if I take that person out, they're not going to select surgery if they have to have 6, 8, 10 weeks of recovery where they're not weightbearing. This was magical to that patient.

They come in asking for this because they say, "I hear, I can recover much faster. And it's true. And that's what we show in our studies that average weightbearing is at 10 days, average time into boot is 6 weeks. And that's founded in 21 publications now, and we're pushing envelope further for the future, which I think is going to be fun stuff as a researcher that's making a fun for me. So that's where we go with that. So what does the Mini-Incision look like? -- is before a large bump on the underside of the foot. It's been corrected after 6 weeks and almost an invisible incision. These are not doctored pictures. And you can see the incision over here is just really almost not visible.

And I don't have patients coming in and asking me, well, how big your incision will be doc, never. I never have that happen. I mean, never is not the right word. Maybe 1 out of 200 patients, they really are just concerned about cosmetics and they're not there for the right reasons, and they rarely need a bunion correction in that patient. But they come in saying, how fast can it get back to work. This is why the iterative approach we've taken, it's gone from the standard to the Mini-Incision and the future being the micro incision is going to be important. So we studied this too.

So Paul showed you the ALIGN3D data. We're doing the Mini3D clinical study that's just getting started. It's also a prospective, multicenter, unblinded study. This primary endpoint is as we look at the radiographic outcomes 24 months. It also have endpoints of function as well as range of motion of the great toe, which we believe is linked to swelling and linked to speed of recovery and speed to weightbearing.

So we want to treat up to 200 patients at 20 centers and a study has just started, and we will be having our first patients treated and results at 1 year and about a month. So we're getting close to getting of those, which we if you haven't been familiar with our data, we presented at every major society meeting we can, the ACFAS and AOFAS every 6 months, they're about 6 months apart. And we've been able to be active at those meetings with those results every time. So now we're on to those. I'm the Medical Monitor of that program as well as the previous Line 3D, and it's been very satisfying to see those progress through.

So again, the iterative approach shows us that we have taken 3 instruments down to 1, now that we have the 3-n-1 guide. So this is where we improve on things. This is why our surgeons like to come back. They like the precision of our instruments the way they work. And we'll never sacrifice how they work and just make them better and they are universally complementary about how that approach has helped them and now speeds up their time in the OR and gives the results that they are looking for.

A recent survey showed that 15% reduction in time at the Lapiplasty procedure when we went to the 3-n-1 Cut Guide. Again, that's the fulcrum, seeker and the cut guide all in one. So instead of placing 3 instruments and keeping them all aligned and doing 3 different steps, it goes to 1, and so that's a 15% reduction in time, thinner material, more able to see around and through it with the x-ray, this is x-ray-guided surgery. And so that helps speed of x-ray time and less of x-rays taken on average as well in my hands. So 3.5-centimeter input and the technique will get down to this

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3-n-1 guide, and that's where we will be transitioning to hear the next iteration, which will go into the midfoot, which is the Adductoplasty that Dr. DeCarbo is going to talk about and we'll go from there. Thank you.

William DeCarbo

So great job, Paul and Bob phenomenal. It's interesting because the concept of paradigm shift I love, and that's really what Lapiplasty did for forefoot reconstructive surgery, bunion surgery. It was kind of like the earthquake, if you will, of the industry. And Adductoplasty is the after wave or the shock wave after that. It is equally paradigm shift in how we treat midfoot deformities that are just difficult and we've never had an answer for initially.

So I'm going to go through this with you today, the Adductoplasty system and also talk about the Triton. One of the things that's so unique about this company and this surgeon advisory and the group of engineers that we have is this constant innovation. So not only are we innovating products and procedures that literally revolutionized the industry of foot and ankle surgery.

But we're also coming up with instruments that directly help to get these procedures accomplished. So if there's a step and we don't make the instrumentation we design our own. And so this is one of the products. Jody will talk about another product, the Triton, this is a sterile-packed instrument release that we'll discuss.

The first thing we have to talk about, I think Paul and Bob did a great job talking about bunion. What is a bunion deformity, and it's essentially where that first ray is deviated out of position on all 3 planes, and then that creates the clinical bump that patients express and talk about and that is a painful deformity for that. And if I put up the lines, you can see and Paul mentioned this, all the metatarsal should be parallel. And then when you get into a bunion, the first ray or the first metatarsal is deviated out of position. So that is a bunion that was discussed very well.

What is metatarsal adductus. Well, metatarsal adductus, we call it a bunion plus so to speak, when the patients come in. And what that means is the first, second and third metatarsals are deviated into the midline of the body. And this is a major deformity. It's a major deformity, not only for footwear, but every day walking, running anything you want to do, the entire mechanics of the foot are off and you can see the depiction showing that, and that translates force instead of distributing that force from a heel-to-toe gait, it translates into the ankle into the knee, into the hip, into the back. And it becomes a debilitating condition, and there's no real answer for this.

What we've recognized through the literature, about 30% of patients that present with a bunion deformity also have concomitant metatarsal adductus. So this is a big number because up until Adductoplasty, we didn't have any answer for this. We didn't have a consistent reproducible result in how to fixate this. Why is this so important? It's so important because the first metatarsal as being anatomically corrected back to 0. And our studies show anywhere from 0 to 4.6 degrees, a normal bunion range is 0 to 9 degrees. And this is correcting with Lapiplasty, you can see all the way to the right picture, 0 to 4.6.

So what happens in metatarsal adductus is the midfoot deformity, the medial deviation or the midline deviation of the lesser metatarsals actually compete for the same space that we want to put that first metatarsal. So if we draw this line, this line represents parallel. So if I put this metatarsal back to parallel with Lapiplasty procedure, this gives me an anatomic alignment, and it parallels the metatarsal just like we said, are so important, and that's an anatomic foot. That's a normal foot, without any deformity.

In metatarsal adductus, if we draw that same line, you see it often bisects the second metatarsal. So what that means is it competes. So the first and second metatarsal compete for anatomic alignment. So there's literally no room or no space in order to get that corrected. And so with the metatarsal adductus and the Adductoplasty system that gets the central rays, second and third metatarsal out of the way, in order to expose the true deformity of the first ray and then proceed with the Adductoplasty. So it's a mechanical blockade.

Why is this so important? This was our idea of bunion surgery with metatarsal adductus in the past or before Adductoplasty system. And often, it was just simply ignored. What would happen, we didn't have a good answer for it. Most surgeons have never dissected down through the midfoot and done a correction after they've dissected down through that midfoot. This is a very complex surgical case and a very complex deformity that we didn't have an answer for. So you can see the reduction of the bunion correction, the bunion is still there. There was really no fix for it. Now this

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was recognized, and then what some surgeons would do would take the heads of the metatarsal and try to cut them, and ship them out of the way to get an illusion clinically of a corrected deformity. But as you can see radiographically, there are just now 5 deformities instead of a corrected deformity.

I've often said we lecture all over the country, usually a few times a month. If you take the screws and the hardware out of these x-rays and you show it to anybody that foot, they'd be like man, that foot is messed up. There's something really, really wrong with that. And you can see from the pictures we've shown in previous lectures and the one in this lecture, if we just erase the plates and screws, it's a normal foot. And that's really the driving force and the sentiment behind Treace Medical Lapiplasty, Adductoplasty, how do we get back to normal alignment, because normal alignment equals normal function, and you see the results in our long-term studies. So this was borne out of a freehand technique.

Just as I said earlier, what was happening as Lapiplasty, we started to evolve and the surgeons started to be more comfortable in this procedure was getting more precise. We realized we couldn't get down to that 0 or 4.6, 4.5 degrees in a lot of patients because we had this mechanical blockade of the midfoot. So what we did, we started discussing it. And we went back to the root problem, the core, if you will, right at the tarsometatarsal joint, same concept as Lapiplasty, and we started making a wedge cut free hand.

We took those metatarsals as 1 unit. We made a cut with the base lateral, apex medial and we swung those around, put on the Lapiplasty plates. As you can see, this exposed the true deformity of the first metatarsal or the true deformity of the bunion. And then once we had that, we could proceed with our Lapiplasty technique, and you see the alignment and the reduction. So that's kind of the genesis as to why it happened and how it came about.

One of the things that's so interesting, you see the reduction of foot lift. And we published a paper showing this on average, we had about a centimeter of foot with reduction for Lapiplasty alone. And then when we got into a Adductoplasty, it could be upwards of 2 centimeters at times. Why is that important? Imagine trying to fit a shoe in a foot like this and then distribute weight in a heel-to-toe gait. It's an extremely debilitating condition and a deformity that needed -- addressed.

Just like Lapiplasty, we broke it down into 4 broad-stroke steps, if you will. We (inaudible) the joint to make it 1 monolithic structure, so to speak, between the second, third metatarsals. We cut it with the cut guides and I'll show that in a minute. We compress it, and we fixate it. Why is that so important? This was a deformity that had no answers. We instrumented it not just for reproducibility, but most of us in this room and most surgeons around the country are doing this procedure in 35 to 45 minutes.

So you took a deformity that you had no answer to, and you made it a complete anatomic reduction that speaks to function, and you did it in sub-60 minutes. A moonshot from where we were and what we are doing. It's the first comprehensive system of this kind. So just like everything else with Lapiplasty, it is instrumented for reproducibility. We have the plating system for the midfoot fusion, and we're getting the reproducible results, just like we're seeing with Lapiplasty.

The kit is super streamlined. This is it. This is the entire kit. So this is very user-friendly for the rep, for the surgeon and for the facility. So really important, this isn't a huge capital investment, so to speak. This is the entire kit that comes in this. We have different iterations of the cut guide. We have 2 different wedges, and then we have a small, medium, large depending on the size of the foot. The small, medium and large are the width, not the cut angle.

And just like Bob had mentioned in regards to the first Lapiplasty, there has been so much thought into this angular deformity. This isn't just random numbers. These are really thought out and tested time and time again. What's interesting about this is there -- for midfoot deformities, there's deformities that don't have metatarsal adductus and they just have arthritis of the midfoot of the second, third specifically. It's a common condition, probably about 10% of patients present with it.

And we have a single 0 angle cut guide and the double. So if they have isolated second tarsometatarsal arthritis, we have a cut guide just to fuse and prepare that joint. And if they have the second and third, we have a [zero] guide to handle that as well. The compressor was redesigned because it sits in a little different position. It sits off the lateral side of the foot. And because of what we call the transverse arch of the foot, this has to kind

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of hang off. We've designed this so we can cut it, correct it, compress it, and then plate with that compressor on, which saves an enormous amount of time and enormous amount of headache.

So the design system is really user-friendly to the surgeon. When we do internal surveys, 85% of the surgeons are interested in getting this training. Now why is that?

There's no answer. We have surgeons that are now doing Adductoplasty midfoot deformities that have never done it, maybe in their entire careers, residency, fellowship clinical practice. Why? Super hard to correct and no really answer. There's no consensus. There's no way to do it. Of that, 16% of those surgeons say that they would benefit -- their patients would benefit from Adductoplasty. Now why is that number so important? We've already showed the 30% statistically of bunions have concomitant metatarsal adductus. 16% of surgeons getting trained are saying, "Hey, I can use this right now for our patients. So that's another 14% of surgeons that as we continue our training, as we continue our research, as we continue our publications, that we're gathering all that basis of surgeons and patients to utilize this system.

So absolutely enormous step in midfoot and forefoot surgery and the potential is just widespread because, again, there's no answer to a very complex problem. These are just case examples. And as I said earlier, if we just took out all this hardware, that is a normal foot. And that is the overarching concept of Lapiplasty. When you saw the other procedures done or the -- what we call MIS surgery with poke holes, we're creating another deformity of the foot clinically, it looks like it's corrected. But radiographically, it certainly is not and functionally, we don't know if that's going to hold up over time. We have data that's showing that ours hold up over time.

So you see the 2 different iterations of Adductoplasty, and then you see midfoot arthritis. So this is a patient that presents and she has arthritis, this patient is mine. Through that second and third tarsometatarsal joint with the zero angle cut guide, we can prepare that joint quickly and then compress it with the compressor. And then we have the plating system that goes over top.

So those are the 2 main structures with that. Clinical pictures we showed for the previous case, and we want to show this as well. I will note just like Bob did the scarring. So the scarring for this is super good. Most of the time, that scar continues to fade over years. I tell people -- most people have some sort of orthopedic surgery in their lives, and you're not walking around with all these scars. So those scars dissipate over time.

But this picture is not really for the scar. So I would really want you to focus on the deformity. Imagine shoeing this foot, imagine walking, running, performing any significant activity with a foot like this. This is a significant deformity of the midfoot and the forefoot. Even the toes are involved. We showed that radiographically and now you can see that clinically, whereas the metatarsal adductus, the bones have this midline deviation into the body. At the same time, the toes have what we call fibular or lateral deviation of the body. So it is a drastic deformity that had no answers until Adductoplasty. So we're super happy with it..

Just like everything we do at Treace Medical, we publish and we research and we report data. Super important. This is a conjecture. This is in our opinion. This isn't, hey, look what I did. This is a studied concept -- studied procedure, not just with radiographic alignment, not just with fusion rates, not just with recurrence rates, but with function -- and function is king. We want patients back to normal activity as quick as possible, and this is what this is allowing to do. This is the first paper that we published on this. This was the freehand technique.

Again, this was the genesis behind how do we develop a system that can be reproducible just like Lapiplasty and have multiple surgeons regardless of training or experience, be able to do it. So this was the first paper. Concomitantly, we are collecting retrospective data. And just as Bob said, that has been reported at the American College of Foot and Ankle Surgeons Scientific Meeting. It's the Annual Meeting in the American Orthopaedic Foot & Ankle Society annual meeting for this.

And we're in the process of initiating a multicenter prospective study. So not only are we publishing here's the technique, here's what we're doing. Here's how our patients have done so far. Here's what our patients are going to do in a randomized prospective study. So every level of reporting and every level of data through the literature, we are doing and just like Paul talked about the ALIGN3D, similar concept, multi-centered study, multiple surgeons around the country use the system what's our outcome. So the data will support this and bear this out. So that is Adductoplasty.

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Again, if the earthquake of the paradigm shift in forefoot, midfoot surgery is Lapiplasty, this is the aftershock. I mean, this is a big deal. Of this, when we do this, we realize there are certain key steps to these procedures, and we need instrumentation. So this is one of the instrumentations that we designed. This is a sterile packed single-use instrument that we designed, it's called a Triton.

So Triton is analogous to an osteotome. An osteotome is an orthopedic instrument for the sake of conversation, kind of looks like a chisel, it's made to cut bone, it's made to break up subchondral bone plate. It's made to release tissue. It has multiple uses. But most of the time, in the hospitals and surgery centers and whatnot around the country. One, it's not very sharp. And two, it doesn't have a handle that you can actually grab and foresee it. It's just like having a piece of stainless steel with no real shape within your hand.

So we noticed that, that was a problem early on. For the Adductoplasty procedure, there is a soft tissue release that is critical between the base of the third and fourth metatarsal. And what we have done is designed an instrument specifically for that because it's single use and it has the tri-cutting edges. It works super quick, super well, and it releases that tissue.

Now one of the things about that because it's PillPack, what we've noticed is we can use that instrument in every type of Lapiplasty Treace medical case we've done, even cases that aren't specific to forefoot or midfoot surgery, this is a great tool. So we've started to -- it was developed for Adductoplasty. We've used it for Lapiplasty. We used it for first metatarsophalangeal joint or big toe fusions. You can use it for a plethora of other reasons. So the nice part about this because it's PillPack the surgeon can just ask for it, and then they have it right on to the field.

So -- that is the 2 charges that I was given in regards to Adductoplasty and Triton. These are big deals, because we're so passionate about it. You hear us talk about it. Obviously, that we're here with the company, but we're surgeons that face patients every day. And there is nothing more daunting than looking somebody in the eye, telling me you have a problem. I'm going to help you and then follow them for a year with their families in the room and their kids in the room and everything. It is a pressure situation. And with Treace Medical with Lapiplasty and Adductoplasty, it took that out of it. And Paul and Bob kind of spoke about that earlier, it's enjoyable. Now we see those patients come in with that a drastic deformity, whether it be in the midfoot, in the forefoot and like all I can help you and I know exactly how it's going to come out.

Before it was a coin toss. You did the best you can in surgery. You waited for that post-op visit looks good. And then about 6 weeks, 8 weeks, like Paul said, they started to walk on it, you're doing this. Please stay the way I think it should or where I put you. We don't have that issue anymore with this instrumentation and with this system. So we're super excited to kind of share that with you guys. So with that, I thank you. And then the next reiteration, Dr. McAleer is going to talk about the microincision. So thank you.

Jody McAleer

All right. So you guys can hear me okay. So this is probably going to be the most challenging lecture of the entire panel because everybody said everything that I was already thinking. So that's a big problem. But that's a good thing because everyone is working together, working in concert, we're all thinking the same way we're all pushing this paradigm in order to bring our patients the very best products, the very best surgical outcomes that we can.

And true to what Bob and Paul and Will said, you have to look at these patients when they come into the office. You have to follow them. You have to be able to look somebody in the eye and say, I can fix this problem for you. I can make you better. And the outcome that I'm going to tell you about is what you should be expecting. And so we want the outcome to be consistent, and we don't want to have a deviation from that.

So this is -- I'm from Jefferson City, Missouri for disclosures. I'm from New York, all right? Just so everybody knows that in the room. I just want you all know that I'm from Yonkers. So I grew up here, so don't think that I'm a former. So anyway. Okay. So we're going to just kind of hit on a couple of additional topics. I know you guys are looking to probably get this wrapped up here in a little bit. But I've been asked to talk about the micro procedure.

So we're going to touch on that, and we're going to talk about why the microprocedure is different from the Mini that Bob talked about and also the traditional open procedure. We're also going to touch on these speed plate, these rapid insertion plates that can be used in pretty much almost

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any of these procedures that we're talking about, whether it's for Adductoplasty, whether it's for TTR or -- in the form of Adductoplasty, whether it's going to be an open M&E or a micro.

And then we're also going to touch on this new instrument called the SpeedRelease, which, again, like the Triton, Will, was talking about, it provides a specific role in giving the surgeon an opportunity to perform the procedure with greater ease and also with reproducibility. So everything that we do is centered around making the surgeon experience better, which ultimately makes the patient experience better because the outcome is better.

So you saw this slide before, Bob showed it Bob's an orthopedic surgeon. He knows what this is. This is a shoulder. I'm not as familiar in this part of the body because I do foot and ankle. But MIS or a smaller incision, is that better? Does size really matter when we're approaching these patients in doing these procedures. So in this case, yes, shoulder surgery, arthroscopic surgery, small incision, smaller approach means less soft tissue disruption, which means that the patient potentially would have less swelling and less discomfort post procedure. But it only counts if you're doing the procedure correctly, so you can make a tiny, tiny incision and be terrible at what you're doing. And you can have a very bad outcome for the patient. So smaller is not necessarily better.

And that, unfortunately, has been what the current MIS platforms have gone to. They said, "Well, let's take these traditional osteotomy procedures where we're physically deforming the bone. And in their mind, they're not using the word, deforming, they're using the word, correcting. And I use that word very loosely because the concerns associated with bunion surgery, all these reported outcomes of reoccurrence. Are they truly a reoccurrence? Or are we just under correcting the problem to begin with? And have we done the patient ultimately a disservice by providing them something like that, where we just permanently change the anatomy of that metatarsal and we call that normal. We've convinced ourselves, this is normal. This is what the professions have done. And we've been taught to this. This is what I was taught to do when I was in school, just like everybody else on the panel.

So smaller does not necessarily mean better if this is going to be the result, okay? So if we take a look at these examples here and we compare, again, a normal foot and we look at these 2 outcomes, and I look at this one here in the center, and I see this cutting and shifting the bone. I see the placement of this hardware. And I see essentially, we call it the intermetatarsal angle, which is the angle between the first and second metatarsals, you're physically jacking open this portion of the intermetatarsal angle, and you're potentially gapping and shifting this portion of the joint.

So how is that restoring normal anatomy, when we look at the example on the far left. So again, if you cover up that hardware and you made the hardware disappear out of these 2 pictures. And I show you a normal foot, which 1 of these 2 examples in your mind, as a layman and as surgeons, which one is normal. And I understand that patients understand that and anyone that looks at this, you can see them understand it. What's interesting also is that some of these MIS options and even some of the open osteotomy options, you'll see a re-creation of the bunion because this joint tier, this first tarsometatarsal joint remains unstable. So as this bone continues to shift and that gap between the first and second metatarsal widens over time as this fails mechanically, patients may not get a recurrence to their bump here. But sometimes they actually have a physical reoccurrence of the bump at an area a little upstream from where the original problem was. So now you've actually created a new problem for the patient. And how do you correct this afterwards? How do we fix this when this fails?

And this is something that we talked about on a routine basis. How do we solve this problem that's being created out there in the market. And so we're going to find an answer. We're working on it. We have an answer now, but we want to find the very, very best answer possible. So not just to attack and, yes, but we said there's such a trend, patients maybe want this. They want a smaller incision. We want to provide them with a more rapid recovery. There's a smaller incision equal less swelling, less pain like I stated before.

And so we said, "well, can we do better? Can we do better, but can we stay true to the 3-dimensional tenets of correction, the philosophical approach, that is Lapiplasty. That is Treace Medical concept, that's what we are built on and just as we do with the Adductoplasty. So that's where the Mini came from, right? So we go to a 3.5-centimeter incision. And I can tell you, Bob's medical monitor so I'm the lead PI or a Primary Investigator for the U.S. on this study. And I can tell you, we can get this incision down, in some cases, to 3.1, 3.2 centimeters.

And we're high 5 and as we're walking out of the operating room because we know that we can shrink that incision and I got the correction that the patient needed all right? So the patient comes out of the OR, and maybe they're happy because they have more cosmetically pleasing scar,

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maybe they're happy because they have less swelling, maybe they're happy because they got the correction that they needed. I know why I'm happy because I got that thing corrected, and I know that the studies that we have out there show that there's going to be less than 1% reoccurrence rate on this, according to the Line 3D so we say, well, can we do better? Can we do even better?

So we went back to the drawing board, the engineers, the surgeon team, and we've been working on this in the lab, how can we solve the problem of the MIS question. So when a patient comes into a surgeon's office and said, well, I heard about this protocol, a small-incision approach, can you do that for me? And we want to be able to say, yes, we can because there is a market for that. But we want to do it our way. We don't want to compromise our tenets, philosophies and approaches in order just to give a patient a process that they view as better.

So everyone likes to say to things like lunchtime surgery. Okay? This is not lunchtime surgery. We're talking about lifetime outcomes. So that's what we want for our patient. So we went back to the drawing board and we reach the process in which we did procedure in order to make it stable, reproducible and to give the patient that outcome they're looking for.

So what this -- what it incorporated was the use of some of the instruments that we've used in the Mini, okay, like this external position or cup that Bob alluded to, which is a device. Okay. So this goes over the outside of the skin. And this allows you to maintain without having to make (technical difficulty). Okay. And then you could see the implants as well look different. But again, 90-90 construct, biplanar plating, this is what we're looking to do.

And so with this came (technical difficulty) incisional guide in order to identify our incisional area radiographically, so we don't have to start with dissection, but instead, we can identify that target zone prior to even having to open up the soft tissue upon, specific instruments that procedure for removing the slices after the bones are cut, moving any type of soft tissue interference at this attachment, the cut guide and also the compressor, all (inaudible) geared to go along with this particular incision.

And this is -- this right here is the star of the show. -- what's known as a 3-n-1 microincision guide. And what this does is it marries together 3 very important and specific instruments that we use during this procedure, where with the original system -- these are all independent instruments. So a fulcrum, a seeker and a cut guide, all of which were important because 1 instrument would be used to maintain a position in the metatarsal. One would help you align your cut guide at the joint in preparation for making the bone cuts.

And then third would be the cut guide itself, which went on top. So we and surgeons would have to go in and individually put these instruments in, make sure everything was appropriately aligned, make sure that the ratio between the instruments was just so before we made our bone cuts. But now we have 1 instrument and we just drop it in physically into that soft tissue pocket, again, through that smaller aperture. And you can see here live case measured out at just sub 2 centimeters.

So along with this process, now I asked Sean to put this slide in here early. This is that additional instrument. Now this is not specific just to the micro procedure can be used with the Mini and it can also be used with the open. But so this instrument is known as the SpeedRelease. And so the SpeedRelease has a very specific function. Part of the procedure is releasing the soft tissue here at the great toe joint.

And why that's important is because the soft tissue that binds the great toe joint, the sesamoids, the metatarsal, the or the great toe, those bones that soft tissue is covering that area and the soft issue becomes contracted with these deformities. And as the patient gets older, that contracture can worsen and it can be very difficult to get the first metatarsal to come back into position.

So by doing an appropriate release at this area, and it allows us basically to uncouple those 3 bone segments and push everything back into place. The issue is traditionally some of us have not been very good at doing this. And when I say some of us, I don't mean us here on the panel, but I mean surgeons in general. It can be a challenging procedure. It seems like it's elementary. It seems like it's simple, but you have a confluence of multiple soft tissue structures, capsule, ligaments, tendons.

So you have all these different components that are coming into this area. And so this is sped up. So this is from one of our instructional videos. This is us doing a Mini-Incision. This is our instructional video for that. And you can see all this manipulation in and out with the scissor, releasing the capsule, coming back around, trying to fit that in.

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And so again, trying to get this release done, and you may have to go back and forth, and go back and forth a couple of times, which adds time to the case. It decreases efficiency, and it also causes the potential chance for additional trauma in this area for the patient's anatomy. This is the SpeedRelease, small incisional pocket, drop the band at tip of that instrument into that joint capsule, simple push done, 1, 2, 3, nice and easy.

And so this can be used, again, cross-platform regardless of the particular procedure. I know we're highlighting micro, but micro, mini, open, Adductoplasty, and this can also be used to break down tissue at other levels in the foot as well as required. So there could be potentially some distant anatomical options for use of this instrument as well.

So going back to the micro, instrumentation, also we require new implants. So we have this biplanar construct, all right? So played on top, played on the side, approximately 90 degrees from one another in order to maintain stability and hold the joint in place. So for any of you that are familiar with external fixators or those halo fixers for people that you see, if they're in traction or if they're broken bones, this internal fixation is akin to that external fixation process. It just holds from multiple angles to maintain stability while the bone heals, following your correction.

So we have 2 variants here. So we have a SpeedPlate, which goes hand in hand with the micro or the mini incision. And so this is essentially not a staple, but rather a plate that fits into the bone and it has some memory to it. So we straighten the plate out a little bit, we've drilled 2 holes and we dropped the plate into the area here and you can see this one is on top, that one is coming in from the side, and that gives you your complete control. And we have multiple bone -- I'm sorry, multiple sizes for this implant, 18, 15, 20-millimeter just depending upon the patient's unique anatomy. So we can fit around that patient's anatomy and if we need to span across that joint a little bit larger, a little bit smaller, just depending upon that particular individual.

So as we move to a smaller incision, we're not abandoning the open procedures as well. So we're constantly trying to innovate. So for surgeons that may still want to make a larger incision, we also have a [quad] version of the SpeedPlate, which again is almost a replica of our current plating system that takes 4 screws -- 4 locking screws. So this will function and act in a very similar fashion.

And they've done -- the engineers are phenomenal at Treace and they've done some biomechanical testing on this, and it shows that this is a very, very strong plate, very strong construct and the outcome should be very similar. So you can see the quad plate. I don't know if you can see it with the monitor with the stage here, but you can see this is the quad plate on top with a mini or a smaller SpeedPlate on the side. So these are some of the additional offerings. Again, we are constantly innovating, constantly looking for the next best way to do the procedure, and we never settle. We never say we have it. It's good enough. We always want to make it better, and we always want to make sure that we're providing our patients with the best outcome possible. Thanks.

Operator

Thank you very much, Dr. McAleer. So this concludes the formal presentation of our surgeon adviser event. We will take a few minutes to pause as the webcast ends and as we shift towards our surgeon panel discussion.

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