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EDITED TRANSCRIPT

JNJ.N - Johnson & Johnson at Stifel Healthcare Conference

EVENT DATE/TIME: NOVEMBER 18, 2024 / 3:55PM GMT

OVERVIEW:

Company Summary

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Michael Bodner *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

CONFERENCE CALL PARTICIPANTS

Rick Wise *Stifel Nicolaus and Company, Incorporated - Analyst*

PRESENTATION

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

Okay, everybody. Rick Wise again here, and it is my pleasure and truly my privilege to welcome J&J to the 2024 Stifel Healthcare Conference.

To my left, Michael Bodner, Group President, Heart Recovery and Circulatory Restoration. In the audience, two friends from Investor Relations, Alec Mast and the wonderful Tracy Menkowski. Welcome to you both as well.

Michael Bodner has led both the Abiomed and Shockwave franchises -- just for perspective, it's about 3.5% or so of J&J total sales at this point -- since their acquisitions in December of 2022 and May 2024, respectively. Michael is a seasoned interventional cardiology exec,15-plus years experience, and was previously Worldwide President of J&J's global, leading, amazing Biosense Webster EP business.

As a little fact, I went to Israel before they ever came -- or near J&J and visited Shlomo Ben-Haim way back. That's way back when.

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Back when it was in Yoknam -- no, Haifa, before I moved to Yoknam.

QUESTIONS AND ANSWERS

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

So Michael, I was at TCT, and I just thought we'd start off with some post-TCT reflections. J&J spent $30 billion to bring both Shockwave and Abiomed under the J&J umbrella. With these two companies inside, I noticed that J&J had a huge presence at TCT on the floor and at clinical sessions.

Just wondered, just since we didn't get a chance to meet there, what were your impressions of the meeting and the customer interactions and clinical data takeaways? What were your high-level impressions from this year?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Well, thank you for the question, and thank you very much for the warm welcome. And good to see everybody here today. TCT was filled with energy for us. It was exciting to be back and reengaging with interventional cardiovascular.

As you know, it's been a while since we've played in the interventional cardiovascular space, as I define it, coronary, peripheral, and heart recovery in terms of heart failure. But our presence was great.

We had Abiomed and Shockwave right next to each other. And above, we had this big, red banner, J&J MedTech. And the booths were packed, and we had some really nice cross-pollination of customers moving between Abiomed, learning about Impella heart pumps; and Shockwave,

learning about intravascular lithotripsy. So it was a great event for us, lots of good data readouts and lots of new products that we're introducing and discussing with customers.

From a data readout perspective, on the Abiomed side, we released the data on ECP. So ECP is our expandable cardiac power device, that's our next-generation Impella pump. That's 9 French, expandable up to 21 French. That's going to be easier to use and expand user pools and help us address more patients with high-risk PCI. And that study met its primary safety and efficacy end points.

We also did some deep dives on DanGer Shock. DanGer was a study out of Denmark and Germany, hence the DanGer name. And this was an AMI cardiogenic shock.

Now in that patient population, these are major heart attacks where patients, a lot of times, are unconscious in cardiogenic shock, meaning the heart is no longer pumping. This was a study that took 10 years to run in 360 patients.

And we found that there was a mortality benefit, a significant mortality benefit, of 12.7%. The relative benefit was 26%, meaning one in every eight patients that got an Impella heart pump versus standard of care had a survival benefit. This is going to change the standard of care.

We also had a lot of different events, talking about tips and tricks and how to best optimize the procedure for Abiomed. But we are introducing technology that is optimizing the procedure, making these devices easier to use, lower profile, longer 12 times, and we're going to be able to expand the types of patients that we treat.

On the Shockwave side, we announced the completion of the Empower study. This is a study just in females. So females, a lot of times, are underrepresented in clinical studies. They're harder to treat, vessels are smaller, and a lot of times, there could be more calcium. So we just completed that study, and we look forward to that readout.

And we also showcased two new launches that we've had since we acquired Shockwave, E8, which stands for 8 lithotripsy emitters. And E is more like expandable or extended. This is a peripheral product, and it's performing extremely well.

And then we have a new device -- that it's not a balloon catheter. That is a CTO catheter with a lithotripsy diode. Emitter, actually, is on the distal tip, and that helps push through total occlusions where the cap of that occlusion is calcified. And we can push through.

So lots of good energy at TCT and a lot of significant readouts and energy around the new products that we're bringing to market.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

And it strikes me -- hard not to strike me that when I think about Abiomed; Shockwave; and most recently, V-Wave, you really are getting back into the field of interventional cardiology under that broad umbrella. But as you said, Michael, you have a long history here, but it's in and out history as we know it.

Do you feel like you're being welcomed back? And maybe as you talk about that silly question, let's address a more serious one. It's hard for me -- let's just hit it right up front. The dream, the J&J dream, that we were talking about, where are we going with all this? What's your aspiration?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

So maybe I can start with -- we are being welcomed back, and it's great to see old friends and colleagues from back prior to the divestiture of Cordis. And the interventional cardiology community has been welcoming us back across interventional cardiologists, vascular surgeons, cardiac surgeons, and interventional radiologists.

We're reentering the space because it's extremely attractive, both clinically and commercially. Clinically, it's one of the biggest unmet needs in the MedTech space. It's a leading cause of death and rehospitalization. Commercially, it's the most attractive. Depending on how you like to size things, it's $65 billion in aggregate, growing 8%, with some of the nicest gross margin profiles in MedTech, generally above 80%.

We want to participate differently than our competitive set. My visual is a backpack filled with rockets, not a big hockey bag of slow-growth commodities. And there's room in that backpack for a few more rockets for sure, but we want to play in a different way.

We want to focus on high growth, high unmet need areas where we can lead and that we provide value for all our stakeholders. Now if we can lead in a way where we're number one or number two, that's part of the calculus. But where we can be the market creator, even better.

And if you think about Shockwave, Abiomed, and V-Wave, those are all in market creation parts of the innovation cycle, where you got to introduce scale and establish the standard of care, these new therapies. And the competition is still relatively far away.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

No, that makes a lot of sense. I'm sure you're tired of being asked about integration. I mean, it feels like the companies are well integrated and you're cranking along. But I had an interesting conversation with a KOL interventional cardiologist last week or a week or so ago. And I said, what's changed from your perspective as a customer since you acquired it?

In his response, nothing has changed, which I thought was the ultimate complement really. Is that -- do you feel like that's how your customers are seeing it and experiencing it? And maybe just as you answer it, what do you hope they'll see different, in a good sense, looking ahead over the next year or two or five?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Well, first, it's great to hear that, and it's intentional. As we look at integrating these companies, we want to do so in a way that minimizes disruption to patients, to customers, to physicians, and to key stakeholders.

Integrations create a headwind, and there's a lot to do. But we have to do it in a thoughtful way that really amplifies access to care. And if it's invisible to our physician customers, then that's goal achieved.

We have a pretty robust playbook that we call on when we integrate these companies, but we take our time to learn about them, particularly with Abiomed and now with Shockwave and soon to be as we unpack V-Wave. But we take our time to learn about their ways of working, their culture.

And in many times, there are things that these companies do that are -- that we can import into broader J&J, and we have been. It's not just introduce J&J culture to these organizations, but also implement some of their best practices into the broader J&J. And so we --

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Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

Hard for me to let that go. In what sense, Michael?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

I would say J&J is a very patient-centric organization. It's part of our credo. It's the first sentence of our credo, actually. But Abiomed is even more patient-centric than we are.

That's because what they do at Abiomed is very much cardiac trauma. We are supporting those cases at 2:00 in the morning, and we are following those patients to the ICU to ensure that they're getting the best outcomes possible. And it's a reminder of just how we put patients at the center of everything that we do.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

No, it makes sense. And just thinking -- again, we're starting off with high-level questions here. How should we think about your M&A strategy? Rockets, I heard you. That will stick with me for sure. That's easy, even I can remember that.

But I mean, again, all under this umbrella of interventional cardiology, and it's a big umbrella, as you've just said. Is this -- should we imagine larger or smaller now that you've got the big rockets, a bunch of smaller ones or?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

I'd say to start off, we're pretty agnostic to small, medium, or large. But to frame it a little bit, I would say Abiomed and Shockwave in the J&J context are medium-sized. V-Wave was small-ish. But if you look at our history over the last 20 years, most of our acquisitions, I'd say 90%-plus, are more tuck-ins, less than $1 billion in size.

But having said that, we're not agnostic to the larger ones if they make sense. So is there scientific differentiation? Is there a path where we can lead, ideally even be the market creators we discussed earlier, and provide shareholder value?

We also have the ability to invest in early-stage businesses through JJDC. And we can invest from seed or Series A/B, or even private investments in public companies.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

You must have been reading my next question. Because I was wondering, are there early stage companies in your VC portfolio already that potentially could find its way into your world? Or the reverse that -- now that in the future, there's going to be more attention paid internally to help you and support your long-term growth or technology goals?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Yeah. We work very closely with JJDC. So JJDC stands for Johnson & Johnson Development Corporation. So this is the oldest healthcare VC in the industry. It's just marked 50 years.

And we work very closely with them. We have a very strong partnership with them. So they know what's on our mind and where we're looking to go.

But the simple lens is high growth, high margin, high unmet need, again, where we have the opportunity to lead. There is room in that backpack beyond the rockets that we placed. And I would say if the right opportunity comes, we'll work within our teams to try to transact.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

And this is totally unfair. I can't help myself, sorry. But I got 50 texts from buy-siders saying, ask him if he is interested in structural heart, TAVR, mitral, tricuspid. I'm lying, but it's a productive ask.

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Well, I'd say that fits the mark of high-growth, high unmet need, right? So high-growth, high unmet need where -- but in a way where we can add value. And again, can we have a leadership position in those with those transactions?

Now it is important to note that we are playing in structural heart. We are playing in structural heart on the Biosense side of the business with Laminar. And our Shockwave business is starting to play in structural heart with innovation around applying that lithotripsy technology to structural heart, either as part of the procedure or as a way of delaying the need for an implant.

Now it's early still. But as you think about TAVR, in particular, many of these patients are getting multiple layers of devices. So if there's a way to potentially delay the implantation, there could be value there.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

Got you. So let's dig into the businesses a little bit. Abiomed -- just thinking about Abiomed performance since the acquisition. Every J&J earnings call I've listened to, I hear Tim Schmidt, the Head of MedTech; and Joaquin Duato, Chairman and CEO, talk about how Abiomed is tracking above your deal models and expectations.

Help us appreciate what's gone so right. Is it just leaving as simple as leaving to their -- what are you doing there if they're just leaving it alone after all? But what are the key drivers here? And help us understand the sustainability of what you're seeing, what we're seeing?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

So we have kept Abiomed stand-alone, but that doesn't mean left alone. But we're being very thoughtful with our engagements. And really, this is about amplifying all the good work that they already do.

In the beginning, it was all around getting our arms around their key talent. And they have an unbelievable talent population, talented population across that entire organization. The know-how is outstanding. The engineering group, the original inventors of the Impella heart pumps, they're still with us.

And the capability around artificial hearts, left ventricular assist devices, tethering systems, percutaneous mechanical circulatory support devices, that know-how is still in our building. We make our own pumps. We make our own motors. We're now making the most -- smallest, most efficient motor in the world out of that organization.

So step one is around getting arms around talent and then investing in the areas that matter most, patient care teams not just at the index procedure, but following that patient through to the ICU and making sure that patient is getting the best treatment possible and that that next nurse showing up at 2:00 in the morning knows exactly what's happening with that patient and with that device.

Two, it's about next stages of innovation, investing in the R&D programs of making these devices lower profile, easier to use, longer dwell times, even more hemocompatible.

Three, manufacturing capacity, expanding our ability to produce these pumps to treat more patients around the world. And four, tapping into our market access teams around the world, particularly in the UK, France, China, and Japan, to open up health economics and reimbursement for making Impella available to more patients around the world.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

I mean, all those are very rich and fertile topics. I was going to ask you a little later, but let's go ahead and ask about worldwide market access and these access teams and the opportunity. Because that was really one of the big promises going in, you just knew it. Where are you in that process? Are we just beginning? Are you in full throttle?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Yeah. We're about 80-20 split, US, OUS. The US has actually been accelerating its performance, and that's because we've been investing in those care teams as we discussed.

OUS, I see that mix changing over time from 80-20 to higher OUS because certain markets are going to come online. The readout of DanGer Shock was very meaningful. That gave us a positive HTA, health technology assessment, in Australia. That's also given us positive engagements with regulators in France and the UK, as well as faster paths in China and in Japan.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

And tying that in to growth -- I mean, I don't know if I have perfect numbers. But pre-COVID, I seem to recall that Abiomed is growing something like 30% a year off a $700 million revenue base. Now, the revenue base has nearly doubled and growth, I believe, is in the 15% range.

Is Abiomed a 15% grower, thinking about all the things you're talking about off this large number? I mean, is it theoretically possible over time to work back toward that pre-COVID 30% growth? I mean, how would you have us think about Abiomed growth over the next three to five years?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Well, I can't comment to specific numbers, but I can tell you we like the momentum. And the catalysts that are coming are very meaningful, and I'm going to break it up in two areas: one, clinical; and then two, the innovation cascade that we see coming through. And we can even touch on the third one of geographic expansion.

But clinically, we have some major data readouts that have the potential to change standard of care. And so I'm going to talk about patient cohorts as a start.

So the first one, we talked a little bit about that AMI cardiogenic shock patient, major heart attack; a lot of times, they're unconscious. And cardiogenic shock means that they're in pump failure, and their heart is just not beating, and their end organs are not perfusing with blood.

Those patients, we now know, based on the DanGer Shock data, that if we give them an Impella, one in eight will have a survival benefit. That will change standard of care for those patient cohorts. And we are developing technologies that are going to be easier to use, lower profile; and we will train physicians and care teams on how to use this technology. That will be a very big growth catalyst for us.

Two, we are actively enrolling in PROTECT 4. We're planning on closing that enrollment in the first part of next year. That's a superiority study. The types of patients we treat are protected, high-risk PCI.

High-risk PCI means that a patient was generally deemed too high risk for procedure. They were being sat on in the community because it was a belief, and there still is a belief, that those patients have the potential to arrest on the table because they're so high risk. Sometimes, they only have a single vessel feeding their entire heart.

When we use an Impella pump during that procedure, it's called protected high-risk PCI. The protected part is twofold. One, it's like a safety net. The Impella is hyperperfusing the coronary artery. So during the procedure, that one single vessel potentially that's feeding the heart dissects or occludes or is blocked. The heart is supported by the Impella pump providing circulatory support.

Two, it gives the physician time. During these high-risk procedures, they're racing against the clock. Time is against them. But if you have an Impella, you have more time. And when you have more time, you can do a more complete revascularization. You're not against the clock.

Many times, these patients have multivessel disease. And a lot of times, the physician will try to pick one vessel to open because, again, they're against the clock. And when you're against the clock, you may not use cardiac imaging, you may not do prebill, you may not double check that your stent was deployed in the most optimal way possible.

So our thesis with PROTECT 4 is that by having Impella to provide protected high-risk PCI, you give that doctor more time to do a more complete job, and that will result to better outcomes. The third study that we just completed, and we had the discussion about it at TCT, is STEMI-DTU. This will be a game changer in how we treat patients.

STEMI is ST-elevated myocardial infarction. This is a major heart attack. And a lot of times, what happens with these patients is they're in extreme pain, and they're flailing, and they're stressed, and they come in an emergency situation into the hospital.

And we've talked about door-to-balloon time, which is how quickly can we get that patient on the table, bypass the emergency department, cross that lesion, stent them, and get them reperfused. A lot of times, though, that blockage is caused by other things other than just the narrowing of the vessel.

The vessel has been narrowing, but a lot of times, it's thrombus that's in the way. And it can be complicated to open up that vessel. And again, that patient, a lot of times, is flailing and is stressed. And the stress level in the cath lab is very high.

The concept of STEMI-DTU is door to unload versus door to balloon, where we put in an Impella pump and we unload the heart. By unloading the heart, we calm everything down. Those patients, a lot of times, fall asleep.

We call it the Impella snore because they're being hyperperfused by the Impella, and they're getting the support that they need. And now, the stress level is down. When the stress level is down and the heart rate goes down, we believe that we can get the infarct size down. The part of the heart that is dying, we can reduce that.

And so with the readout of STEMI-DTU, we're going to look at two things: the size of the infarct, that we can truly get that down because we've calmed down the heart and we've hyperperfused it; and two, those clinical endpoints of major cardiac events in those later periods of time.

But as you can imagine, if you're in your 40s and 50s and you have a major heart attack, the rest of your heart may be in a good condition that can carry you forward. But as we age and we get in our 60s, 70s, and 80s, the size of that infarct is going to matter because the rest of the heart is starting to age.

And so the amount of healthy tissue we have in our heart is going to matter for cardiac longevity. So that's the intention of STEMI-DTU.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

This is exciting stuff, and I see why you're feeling so good. I feel like I better turn to Shockwave here. I told you we needed two hours with him, Tracy. Just obviously, an amazing story you're going to expand.

I feel like there are many elements in Shockwave story that mirror or a companion to Abiomed. Talk to us about the recently launched new E8 peripheral catheter and the pipeline at Shockwave. And how are you feeling about the future pipeline there?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

We're very excited about Shockwave. And I do want to take a minute and explain just the journey that they've been on over the last 15 years. It's taken them 15 years to get to this point.

And the magic of Shockwave is really taking lithotripsy technology that was used for shattering kidney stones and applying it to a simple balloon catheter. As we all age, all of us in this room, we get hardening of the arteries, right? This is calcium deposits start to form, particularly after the age of 60.

That calcium can form either in the surface of the artery or deeper in the layers of the artery. And again, those layers build over time. The traditional way that we've been treating those lesions has either been with a high-pressure balloon, and that's a 40 atmosphere pressure balloon by the way.

Let me put that in context. That's the equivalent of 20 car tires of pressure in a little balloon. That creates a lot of damage. Now that high-pressure balloon can also create a dissection, create a spasm and an acute injury.

The alternative is an atherectomy device. This is like a high-powered drill. There are many physicians that are skilled with this, but not everybody. And so using lithotripsy applied to a standard balloon makes the procedure simple.

We'll take that balloon; and we'll inflate it to 4 atmospheres, just enough to fill the artery and touch tissue; and turn on lithotripsy emitters. Those lithotripsy emitters create a sonic pressure wave that goes through soft tissue without damaging it. And it shatters the calcium, making that vessel compliant so a physician can then open up the vessel and deploy a stent without having a waste and a potential for stent thrombosis later.

The team at Shockwave is taking that technology and making it easier to use. They're making the devices longer. E8 has eight emitters. They're making those emitters have more pulses, faster pulses so it's a faster procedure, and even deeper deployment of those pulses.

And as I stated, calcium affects all of our arterial beds, not just the coronaries and the periphery, but also carotids and the structures of the heart. So as I mentioned earlier, there is a program at looking at calcific valves and can we use lithotripsy technology to make those valves more compliant, either as part of a valve procedure or as a way of delaying the need for a valve replacement procedure.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

And over the next few years, I mean, it always seems like a platform technology, and that's what you're emphasizing here. What are the first up at bat, so to speak, that you're going to focus on or you're inspired to help the team focus on?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

I think the opportunity in structural heart is compelling, but also looking at that form factor and putting it on different types of catheters. So for instance, the Javelin catheter, which is now approved for peripheral use, takes a lithotripsy emitter and puts it distally on a CTO catheter.

So that's a chronic total occlusion catheter to push through the end cap, which a lot of times you'll see in the periphery and the lower limb. That same technology will be applied for coronary use with a coronary version of Javelin to help with chronic total occlusions in the coronary space.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

And Shockwave globalization -- if I remember correctly, Shockwave also maybe had an 80-20 U.S.?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Very similar.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

And do you have a bigger push here in your mind? Is that -- are you focused here on building out the international more than at Abiomed or it's the same initiative or you leverage the two?

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

It's very similar, and it's the similar target markets. So UK, France, China, Japan, we're making big inroads there. And again, we're tapping into the relationships that we have and the expertise that we have in those markets for health economics market access and building out patient care teams.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

Got you. I mean, it's always amazing how fast the time goes. But let's touch on V-Wave. You just closed the acquisition on October 9, interventional heart failure treatment technology company. Just help us maybe better understand and appreciate your vision and where it fits into the exciting landscape you're articulating.

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

So it fits that unmet need area. So if we think about total heart failure, globally, there's about 64 million patients with heart failure. But the population that has heart failure with reduced ejection fraction that are also with no options -- they've been fully optimized with guideline-directed medical therapy. Nothing is working, and they're starting to slip from Class III/IIIB heart failure to IV. IV means you need a transplant or an LVAD.

Those patients, we have seen, in the RELIEVE-HF data that just got released, that they have a 50% improvement in the composite endpoint of death, need for an LVAD, heart transplant, and rehospitalization. And so the way this technology works is V-Wave's Ventura Shunt is placed across the septum of the atrium to relieve pressure from the left side to the right.

Now there is a dichotomous result in this study. We studied both prespecified HFrEF and HFpEF. HFrEF is heart failure with reduced ejection fraction. HFpEF is heart failure with preserved ejection fraction. I think about it as HFpEF -- preserved ejection fraction means that you've got plenty of flow coming out of the heart, but HFpEF patients have stiff hearts.

HFrEF means it's a reduced ejection fraction. There's not enough blood coming out of the heart, and it's a floppy heart. And so when we shunted both patients, there was a negative outcome from an efficacy perspective in HFpEF and a very positive outcome in HFrEF. So those floppy hearts were able to tolerate the volume change, but the stiff hearts were not.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

Interesting.

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

And so these patients, again, they have no option. They've been fully optimized on guideline-directed medical therapy. And if we shunt them, we release the pressure from the left to the right, and that pressure is building up pressure in the pulmonary system. So these patients are short of breath, and they're constantly going to the hospital, being put on systemic diuretics and trying to be optimized.

And so we look at that patient population as significant. It's 800,000 patients just in the United States that HFrEF, are not responding to medication, and could benefit from a shunt procedure. That's about the same size as the US TAVR market, just to put it into context. So it's a big opportunity.

Rick Wise - *Stifel Nicolaus and Company, Incorporated - Analyst*

Amazing. Unfortunately, we have to stop there. But I have to compliment you. I think in my 400 years as a MedTech analyst, I think these are some of the clearest explanations of technology and anatomy. I thought I understood HFrEF and HFpEF, but I think I understand it better now.

Anyway, it's more exciting to see. Thank you so much for spending your time with us. We appreciate it.

Michael Bodner - *Johnson & Johnson - Group President, Heart Recovery & Circulatory Restoration*

Thank you. Pleasure.
