CartiHeal

Agili-C

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STERILE	R

CAUTION

Federal (United States) law restricts this device to sale by or on the order of a physician.

DEVICE DESCRIPTION

The Agili-C™ is a cell-free, off-the-shelf implant for use in cartilage and osteochondral defects in traumatic and osteoarthritic joints. The implant is a porous, biocompatible, and biodegradable bi-phasic scaffold, consisting of interconnected natural inorganic calcium carbonate (aragonite) derived from purified, inorganic, coral exoskeleton (**Figure 1**).

The Agili-C™ implant is implanted using the Mini Disposable Toolset which is supplied sterile, for single use, and the Reusable Toolset.

Figure 1. Agili-C™ Implant

DEVICE SIZES

Diameter (mm)	Lengths (mm)
7.5	10
10	10
12.5	10
15	10

INDICATIONS FOR USE

The Agili-C™ scaffold is indicated for the treatment of an International Cartilage Repair Society grade III or above knee-joint surface lesion(s), with a total treatable area of 1-7cm^2, without severe osteoarthritis (Kellgren-Lawrence grade 0-3).

CONTRAINDICATIONS

The Agili-C™ should not be implanted in subjects with the following conditions:

- Active or latent, bone or joint infection at the surgical site
- Active infection elsewhere in the body
- Neuropathic joint
- Hypersensitive, allergic, or intolerance of materials containing calcium carbonate or coral derivatives
- Critical limb ischemia
- Any known tumor of the knee area
- Severe Osteoarthritis of the index knee, defined as grade 4 according to the Kellgren-Lawrence Grading
- Uncontained lesion - lack of vital bone wall, at least 2mm thick, surrounding the implantation site
- Subchondral bone defect or bone cyst depth deeper than 8mm
- Inability to position the implant 2mm recessed relative to the articular surface
- Osteochondral or cystic lesions larger than what the implant can cover
- Implantation inside avascular necrosis

⚠ WARNINGS

The safety and effectiveness of the Agili-C™ has not been established in patients with the following conditions:

- Morbid obesity (BMI >35)
- Known insulin dependent diabetes mellitus
- Immunocompromised patients, including patients receiving a previous intra-articular steroid injection within the last 1 month
- Systemic conditions affecting wound healing
- Systemic bone disorder, such as but not limited to, osteoporosis and osteogenesis imperfecta
    - The implant has not been tested in patients with osteoporosis.
    - Osteoporosis may impact a patient's ability to integrate the implant and to biodegrade it while forming a new bone.
    - Exercise caution in use in patients with osteoporosis.
- Chemotherapy during the past 12 months
- Ligamentous instability
- Significant malalignment
- Total or subtotal meniscectomy or lack of functional meniscus
- The implant is not indicated for treatment in patients with inflammatory arthropathy or crystal-deposition arthropathy

- Skeletally immature – do not implant the device through the epiphyseal plate (growth-plate)
- Inability to refrain from contact sports or other high-impact activities for the recommended recovery period
- Noncompliance due to major psychiatric disorder, alcohol or drug abuse
- Skin conditions within the field of surgery, such as psoriasis

ADDITIONAL WARNINGS

- The implant should not be implanted through arthroscopic approach. The Agili-C™ should be implanted through arthrotomy or mini-arthrotomy approach.
- The implant is not indicated for treatment in Patellar cartilage and osteochondral defects or for use in other joints.
- Use the device according to the provided instructions.
- The contents of this package are for single use only.
- Do not re-sterilize.
- Do not use the device after the expiration date.
- Do not use if package is damaged.
- Open the package carefully to prevent implant damage.
- Inspect the implant prior to use and not to use the implant if broken.
- This device can only be used by a qualified orthopedic surgeon. It is the surgeon's responsibility to be familiar with the appropriate surgical technique prior to using this device.
- Agili-C™ should be exclusively implanted using its designated surgical tool set. Using any other implantation system may lead to improper device positioning and may cause implant breakage and/or malfunction.
- Creation of an improper implantation site may lead to implant breakage, instability, implant loosening and device failure.
- The defect site must exhibit vital bone on its entire circumference otherwise implant integration may not occur.
- The surgeon must take into consideration the joint geometry especially close to the condyle notch, lateral lesions, and trochlear lesions. If there is a chance of bone wall violation during creation of the implantation site, the implant should not be used.
- The implant must be inserted into the defect in a press fit manner. Non-press fit positioning may lead to failure due to lack of implant integration.
- In case of multiple implants, do not place the devices in an overlapping manner; it is important to keep a bone bridge of at least 5 mm between any two proximal implants to ensure the entire circumference of each implant is in direct contact with the bone, and that the implants are not impinging on each other.
- It is not advisable to apply the device by means of mosaicplasty technique (i.e., kissing implants)
- The implant should be positioned 2mm recessed relative to the articular surface; Protruding implants may lead to procedure failure.
- If the implant is inserted at or above the articular cartilage, damage to the counter or adjacent tissue can occur, as well as particulate debris generation and synovitis.

- Protruding edges of the implant above the articular surface, may lead to implant breakage and/or injury of nearby tissue. It is required that all implant sharp edges be removed.
- Implant fragments or particulate debris may cause an inflammatory response.
- In case of a need of intra-operative revision, remove an implant, and use a new implant of the same size or larger. Do not re-implant the removed implant.
- Avoid entrapment of soft tissue between the implant and the bone which may lead to penetration of synovial fluid, formation of cyst around the implant and lack of integration.
- In case of implant breakage or cracks, remove the implant and use a new one. Do not leave a cracked, fragmented or broken implant in the joint.
- In case of implant removal, carefully remove all remnants and wash the joint intensively. Implant particles, if left in the joint, can cause synovitis and may lead to damage.
- The device is composed of a porous brittle material, applying excess mechanical pressure during insertion may lead to implant breakage and particles generation.
- Do not use excess force during implant insertion; Do not use hammer or any other mechanical instruments for implant insertion, besides the designed Tamper provided in the surgical toolset.

PRECAUTIONS

- The Agili-C™ implant is a biphasic scaffold. The implant surface with the drilled channels is the implant top and faces the articular surface. The tapered side, without the drilled channels, is the implant bottom and faces the bone. Before implanting the device, pay attention to the side to be placed in contact with the bone. Incorrect orientation of implant positioning may lead to improper healing.
- Incorrect use of the surgical toolset can lead to bone breakage, damage to neurovascular structures, bone cyst formation, implant breakage or improper implantation site creation.
- Implantation within avascular necrosis or cyst may lead to lack of implant integration and implant failure.
- Entrapment of soft tissue between the implant and the bone during implantation may lead to small gap followed by penetration of synovial fluid, lack of integration and cyst formation.
- High impact or extreme shear forces on the implantation site during recuperation period, as results of trauma or sports activities, can lead to implant breakage and revision.
- Post-surgical ambulation should follow the physician recommended rehabilitation regime in order to avoid extreme forces during the recuperation period.

ADVERSE REACTIONS

Possible adverse reactions during the post-operative phase include, but are not limited to:

- Transient or chronic pain, including complex regional pain syndrome
- Transient or chronic swelling and/or effusion of the operated joint
- Transient or chronic synovitis
- Transient or chronic Joint locking and/or limited range of motion, stiffness and arthrifibrosis
- Fever
- Bone marrow edema
- Allergic or pseudo-allergic reaction and/or elevation of acute phase reactants

- Pseudo septic reaction
- Reactive arthritis
- Aseptic arthritis
- Bone cyst
- Bone fracture
- Bone deformity
- Osteophyte formation
- Development or progression of osteoarthritis
- Formation of new cartilage or osteochondral defects, or worsening of current lesions
- Bone aseptic or avascular necrosis
- Implant fracture, loosening or extrusion, with or without generation of particulate debris
- Abrasion of counter or nearby tissues
- Failure to induce tissue regeneration
- Tissue formation deficiencies, lack of new tissue formation
- Partial ingrowth, overgrowth, fibrous tissue ingrowth or partial coverage of the implant
- Ligament laxity
- Damage to meniscus
- Joint deformation
- Tissue hypertrophy or inter-lesional bone formation or inter-lesional osteophytes
- Wound complications
- Superficial or deep infections
- Septicemia
- Wound dehiscence
- Intra-articular adhesions, hypertrophic tissue, hypertrophic synovitis or host reactions
- Inflammation of the joint and surrounding tissues
- Deep Vein Thrombosis
- Infection, including local and general complications
- Elevation of the subchondral bone plate
- Degeneration of the surrounding cartilage
- Lack of cartilage integration
- Delamination
- Muscle atrophy

For the specific adverse events (AEs) that occurred in the clinical study of the Agili-C™ device, see the Safety Results in the CLINICAL STUDIES section below.

CLINICAL STUDIES

CartiHeal conducted a prospective, multicenter, open-label, randomized, controlled pivotal study. Subjects were randomized in a 2:1 ratio to Agili-C™ or the control treatment, surgical standard of care (SSOC), with twice as many subjects allocated to the investigational device.

The objective of the study was to evaluate the superiority of the Agili-C™ device versus the current most common SSOC, which consisted of either debridement (for older patients with lager lesions and with OA) or microfracture (for younger patient with smaller lesions and without OA). The primary endpoint for this study was the change from baseline to 24 months in the average Knee Injury and Osteoarthritis Outcome Score ("KOOS") (Pain, Symptoms, Quality of Life ("QOL"), Activities of Daily Living ("ADL"), & Sports).

Subjects were enrolled according to the inclusion/exclusion criteria outlined below. Subjects were required to meet all of the inclusion and none of the exclusion criteria.

Inclusion Criteria:

1. 21 - 75 years
2. Up to 3 treatable joint surface lesion(s), International Cartilage Repair Society (ICRS) Grade III or above, on the femoral condyles and/or trochlea
3. Symptomatic total treatable area 1-7 cm^2. Asymptomatic lesions were not included in the calculation
4. Must be physically and mentally willing and able to comply with the post-operative rehabilitation protocol and scheduled clinical and radiographic visits
5. Signed and dated the IRB/Ethics Committee approved Informed Consent Form and HIPPA (if applicable)
6. Non-responsive to physical therapy for at least 3-4 weeks

Exclusion Criteria:

1. KOOS Pain Subscale score at baseline is less than 20 or more than 65 (scale: maximum pain =0, pain free =100)
2. Bony defect depth deeper than 8mm, according to baseline MRI/X-ray/arthroscopy
3. Articular cartilage lesions in the tibia or the patella, ICRS grades IVa or above
4. Osteoarthritis of the index knee graded 4 according to the Kellgren-Lawrence Grading
5. Significant instability of the index knee according to IKDC Knee Examination Form 2000, Grade C (abnormal) or D (severely abnormal)
6. Malalignment more than 8 degrees varus OR 8 degrees valgus according to standing knee X- ray
7. Lack of functional remaining meniscus, at least 5mm rim at the end of the procedure
8. Meniscal transplantation in the past 6 months
9. Any known tumor of the index knee
10. Any known history of intra-articular or osseous infection of the index knee
11. Any known history of inflammatory arthropathy or crystal-deposition arthropathy
12. Any known systemic cartilage and/or bone disorder, such as but not limited to, osteoporosis, chondrodysplasia or osteogenesis imperfecta
13. Body Mass Index (BMI) > 35
14. Chemotherapy in the past 12 months
15. Any previous surgical cartilage treatment (such as microfracture, ACI, OATS, etc.) in the index knee within the last 6 months
16. Any previous ligamentous repair or malalignment correction in the index knee within the last 6 months

17. Any evidence of active infection anywhere in the body. Urinary Tract Infection (UTI) patients can be included following antibiotic treatment, and provided that two consecutive cultures are negative (taken within at least 2 weeks of each other)
18. Use of anticoagulation medication or antiaggregant medication; however up to 100 mg Acetylsalicylic acid (ASA) daily is allowed
19. History of allergic reaction or intolerance of materials containing calcium carbonate or hyaluronate
20. Patient who is pregnant or intends to become pregnant during the study
21. History of any significant systemic disease, such as but not limited to: HIV, hepatitis, HTLV, syphilis, and coagulopathies
22. Known substance or alcohol abuse
23. Participation in other clinical trials within 60 days prior to the study or concurrent with the study
24. Known insulin dependent diabetes mellitus
25. Unable to undergo either MRI or X-ray
26. Prisoners
27. Previous intra-articular steroid injection within the last 1 month
28. Uncontained lesion – lack of vital bone wall, at least 2 mm thick, completely surrounding the lesion – based on MRI/X-ray/arthroscopy
29. Inability to position the implant 2mm recessed relative to the articular surface - based on MRI/X-ray/arthroscopy

Follow-Up Schedule

Post-procedure follow-up evaluated the patient's knee condition and clinical health. Follow-up visits were performed at 2 weeks, 3, 6, 12, 18 and 24 months, and yearly thereafter until each patient reached 60 months follow up. Anterior-Posterior and Lateral knee X-rays were taken at 2 weeks and 6, 12, 18, 24, 36, 48- and 60-months post procedure. MRI was performed at 12 and 24 months. All complications and adverse events, device-related or not, were evaluated over the course of the study.

Table 1: Study Schedule

Procedures	Screening Visit	Final Screening/ Procedure Visit	2 week Post-Procedure Visit (± 1.5 weeks)	3 μ, 6^, 12 and 18 Months Post-Procedure Visit (± 16 weeks)	24 Months Post-Procedure Visit (± 16 weeks)	Annual Post-24 Months Visit Until 60 Months (± 16 weeks)	Unscheduled Visit
Number of Visit	Visit 1	Visit 2	Visit 3	Visits 4-7	Visit 8	Visits 9-11	
Obtain Informed Consent	X						
Assignment of Subject Number	X						
Review Inclusion/ Exclusion criteria	X	X (intra-operative)					
BMI	X@						
Medical History	X						
Baseline MRI	X*						
MRI according to CartiHeal protocol				X**	X**	X"	X***

Procedures	Screening Visit	Final Screening/ Procedure Visit	2 week Post-Procedure Visit (± 1.5 weeks)	3 μ, 6^, 12 and 18 Months Post-Procedure Visit (± 16 weeks)	24 Months Post-Procedure Visit (± 16 weeks)	Annual Post-24 Months Visit Until 60 Months (± 16 weeks)	Unscheduled Visit
Defect Fill Evaluation according to MRI, off-site				X**,∞	X**		
Baseline standing X-ray (AP & Lateral)	X*						
Weight bearing AP & Lateral X-ray			X#	X∞	X	X	X***
IKDC Knee Examination form 2000 (Surgeon)	X			X∞	X	X	X##
OA Classification Kellgren-Lawrence score, off-site	X						
ICRS Cartilage Injury Standard Evaluation Form 2000 (Subject)	X						
ICRS Knee History Registration (Surgeon)	X						
SF-12 v2	X			X∞	X	X	
2000 IKDC Subjective Knee Evaluation Form	X			X∞	X	X	
KOOS Subscales	X			X∞	X	X	
Tegner score	X			X∞	X	X	
mICRS cartilage injury mapping and classification		X					
Arthroscopy and randomization		X					
Analgesic, anti-inflammatory and prescription medicine recording	X	X	X	X	X	X	X
AEs/SAEs		X	X	X	X	X	X
Tissue biopsy with histology							X****
Video recording - Implantation procedure		X					

@ Weight and Height, only at screening

X-ray may be performed lying down or standing, per patient comfort.

* Screening MRI and X-ray must not be older than 1 year.

** MRI and Defect Fill evaluation is performed at 12 and 24 months. MRI will be performed at 3 and 6 months to an initial cohort of at least 25 patients per study groups to evaluate presence of cysts.

*** MRI and X-ray will be performed according to PI decision.

**** According to PI decision if surgery is performed. The biopsy will be sent to a central lab.

μ The 3 month visit may take place ±2 weeks.

^ The 6 month visit may take place ±12 weeks.

∞ Not applicable for the 3 months visit

“ Optional MRI

According to PI decision

CLINICAL ENDPOINTS

Primary Endpoint

The primary endpoint for this study was the change from baseline to 24 months in the average KOOS Overall Score (Pain, Other Symptoms, QOL, ADL and Sports).

Safety Endpoint

The safety endpoint was the rate of adverse events – including serious adverse events, reoperations and revisions – up to 24 months.

Confirmatory Secondary Endpoints

The study had four confirmatory secondary endpoints for labeling purposes:

- Change in KOOS Pain score from baseline to Month 24
- Change in KOOS Quality of Life score from baseline to Month 24
- Change in KOOS ADL score from baseline to Month 24
- Response rate at Month 24, defined as an improvement in KOOS Overall Score ≥30

Secondary Endpoint

Additional secondary endpoints included:

- Percentage of articular defect fill according to MRI at 12 and 24 months
- Change from baseline in average overall KOOS score (Pain, Symptoms, QOL, ADL & Sports) at 6, 12, and 18 Months
- Change from baseline in IKDC Subjective Knee Evaluation at 12, 18, and 24 Months
- Change from baseline in Tegner score[1] at 12, 18, and 24 Months
- Change from baseline QOL as measured by SF-12 v2[2] at 6, 12, 18, and 24 Months
- Change from baseline to 24 months in the average KOOS Overall score (Pain, Symptoms, QOL, ADL & Sports) in:
    - patients with chondral lesions
    - patients with osteochondral lesions
    - patients with single lesion
    - patients with multiple lesions
    - patients without osteoarthritis (K/L 0-1)
    - patients with osteoarthritis (K/L 2-3)
    - patients with total lesion(s) size ≤3cm²
    - patients with total lesion(s) size >3cm²
    - patients without previous ligament reconstruction
    - patients with intact meniscus
    - patients with previous partial meniscectomy

[1] Tegner Y, Lysholm J. Rating systems in the evaluation of knee ligament injuries. *Clin Orthop Relat Res.* 1985;198:43–9.

[2] Ware J.E., Kosinski M., & Keller S.D., SF-12: How to Score the SF-12 Physical and Mental Health Summary Scales. 3rd ed. QualityMetric, Lincoln, RI 1998.

- patients with concomitant partial meniscectomy
- active patients
- non-active patients

ACCOUNTABILITY OF PMA COHORT

Safety Analysis Set – 251 subjects: The safety analysis set included N=167 subjects randomized and receiving treatment with Agili-C™ and N=84 subjects randomized and receiving SSOC.

Full Analysis Set (FAS) – 247 subjects: The FAS included N=164 subjects randomized and receiving treatment with Agili-C™ and N=83 subjects randomized and receiving SSOC. 3 subjects were excluded in the Agili-C™ group and 1 in the SSOC group due to major entry violations.

Per Protocol (PP) Analysis Set – 246 subjects: There were no additional exclusions compared to the FAS due to a major protocol violation. There was one subject in the study, from the Agili-C™ arm, who withdrew consent prior to the 12 Month visit and did not perform the 12 Month visit. Therefore, the PP analysis set includes N=163 subjects randomized and receiving Agili-C™ and N=83 subjects randomized and receiving SSOC. Thus, all comparisons are nearly the same for the FAS and the PP analysis set.

Table 2. Subject Disposition

	All		Agili-C™		SSOC	
	N	%	N	%	N	%
Randomized and treated (438-187=251)[1]	**251**	**57.3%**	**167**	---	**84**	---
Analysis Sets[2]						
Safety	251		167	100.0%	84	100.0%
Full Analysis Set (FAS)	247		164	98.2%	83	98.8%
Per Protocol (PP)	246		163	97.6%	83	98.8%
Completed the Study[2]	240		163	97.6%	77	91.7%
Early Discontinuation[2]	11		4	2.4%	7	8.3%
Reasons for Early D/C Among Randomized[2]						
Subject withdrew consent	3		1	0.6%	2	2.4%
Lost To Follow-up	8		3	1.8%	5	6.0%
With clinical data without BOCF in Safety Set[2,3]						
Pre-op	251		167	100.0%	84	100.0%
Month 6	249		167	100.0%	82	97.6%
Month 12	248		166	99.4%	82	97.6%
Month 18	243		165	98.8%	78	92.9%
Month 24	240		163	97.6%	77	91.7%

Notes:
[1] % is among screened.
[2] % is among randomized and treated within treatment group.
[3] Based on KOOS Overall Score.

Table 3. Subject Accountability

	Pre-Op		Month 6		Month 12		Month 18		Month 24	
	Agili-C™	SSOC	Agili-C™	SSOC	Agili-C™	SSOC	Agili-C™	SSOC	Agili-C™	SSOC
(1) Theoretical follow-up	164	83	164	83	164	83	164	83	164	83
(2) Cumulative Death			0	0	0	0	0	0	0	0
(3) Treatment Failures			2	3	8	10	10	16	11	18
(4) Not Yet Overdue (no data but still window)			0	0	0	0	0	2	0	0

	Pre-Op		Month 6		Month 12		Month 18		Month 24	
	Agili-C™	SSOC	Agili-C™	SSOC	Agili-C™	SSOC	Agili-C™	SSOC	Agili-C™	SSOC
(5) Expected Due [(5)=(1)-(2)-(4)]			164	83	164	83	164	81	164	83
Within Window Accounting (Actual[A])										
(8) Procedures with KOOS Overall Score in interval†	164	83	164	81	163	80	162	80	158	78
(9) Visit Compliance (%) = (8) / (5)			100%	98%	99%	96%	99%	99%	96%	94%
All Evaluated Accounting (Actual[B])										
(6) Procedures with KOOS Overall Score in interval&	164	83	164	81	163	81	162	80	160	79
(7) Visit Compliance (%) = (6) / (5)			**100%**	**98%**	**99%**	**98%**	**99%**	**99%**	**98%**	**95%**

Notes:
& Clinical values utilizing BOCF for treatment failures are assumed within window.
† Windows defined at exact anniversary +/- 16 weeks (+/- 112 days). Exact anniversaries were defined as 180 (6 mo.), 365 (12 mo.), 545 (18 mo.), and 730 (24 mo.).

STUDY POPULATION DEMOGRAPHICS AND BASELINE PARAMETERS

Table 4 to **Table 8** summarize the two treatment groups at baseline in the Safety Analysis Set. Specifically, these tables summarize the following information:

- Baseline and Demographic Continuous Variables (**Table 4**)
- Baseline and Demographic Categorical Variables (**Table 5**)
- Categorical Lesion Characteristics (**Table 6**)
- Continuous Lesion Variables (**Table 7**)
- History of and Concomitant Treatments (**Table 8**)

Table 4. Baseline and Demographic Continuous Variables – Safety Analysis Set

	Agili-C™						SSOC						Agili-C™ - SSOC[1]		
Demographics - All	**N**	**Mean**	**SD**	**Med**	**Min**	**Max**	**N**	**Mean**	**SD**	**Med**	**Min**	**Max**	**Diff**	**LB**	**UB**
Age	167	42.0	11.2	42.9	21.2	71.8	84	46.2	11.2	46.1	22.7	70.2	-4.21	-7.15	-1.27
Height (cm)	167	174.9	9.0	175.2	155.0	198.0	84	173.9	10.5	175.0	143.0	193.0	0.95	-1.55	3.45
Weight (kg)	167	81.1	16.1	80.0	52.0	123.0	84	84.6	15.0	86.1	55.0	116.0	-3.51	-7.66	0.64
BMI (k/m2)	167	26.4	4.2	26.0	18.0	34.9	84	27.9	3.8	27.6	20.1	34.8	-1.48	-2.55	-0.41
Baseline Functional Status	**N**	**Mean**	**SD**	**Med**	**Min**	**Max**	**N**	**Mean**	**SD**	**Med**	**Min**	**Max**	**Diff**	**LB**	**UB**
KOOS-Symptoms Score	167	53.3	18.3	53.6	3.6	92.9	84	55.3	19.1	57.1	7.1	92.9	-1.96	-6.86	2.94
KOOS-Pain Score	167	46.9	11.6	47.2	22.2	63.9	84	48.4	10.9	50.0	22.2	63.9	-1.56	-4.55	1.44
KOOS-ADL Score	167	55.1	17.0	54.4	4.4	95.6	84	54.0	15.6	54.4	1.6	86.8	1.04	-3.32	5.40
KOOS-Sports Score	167	25.0	17.9	25.0	0.0	75.0	84	24.0	17.0	25.0	0.0	60.0	0.92	-3.72	5.56
KOOS-QOL Score	167	26.0	16.7	25.0	0.0	68.8	84	25.8	16.5	25.0	0.0	87.5	0.23	-4.15	4.61
KOOS-Overall Score	167	41.3	13.0	43.0	11.8	72.1	84	41.5	12.5	42.8	7.5	69.5	-0.26	-3.65	3.12
SF12-Physical Score	167	36.0	8.1	35.3	17.1	59.9	84	36.0	8.1	36.8	12.5	57.2	-0.02	-2.16	2.11
SF12-Mental Score	167	52.6	12.1	53.8	15.0	73.8	84	52.5	12.7	52.0	22.1	77.4	0.07	-3.17	3.31
IKDC Score	167	36.8	12.8	37.9	6.9	71.3	84	34.9	11.2	37.4	4.6	62.1	1.90	-1.34	5.14
Tegner Pre-Surgery	167	2.5	1.3	2.0	0.0	7.0	84	2.4	1.2	2.0	0.0	6.0	0.10	-0.25	0.44
Tegner Pre-Injury	167	6.1	1.9	6.0	1.0	10.0	84	6.0	2.0	6.0	2.0	10.0	0.02	-0.49	0.53

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.

Table 5. Baseline and Demographic Categorical Variables – Safety Analysis Set

	Agili-C™		SSOC		Agili-C™ - SSOC[1]		
	n	%	n	%	Diff (%)	LB	UB
Number of subjects	167		84				
Males	107	64.1	51	60.7	3.4	-9.4	16.1
Females	60	35.9	33	39.3			
Ethnicity	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Hispanic or Latino	2	1.2	1	1.2	0.0	-2.9	2.9
Not Hispanic or Latino	164	98.8	82	98.8			
Race	**n**	**%**	**n**	**%**	**p[2]**		
White	159	95.2	81	97.6	0.736		
Black	6	3.6	2	2.4			
Asian	1	0.6	0	0.0			
Native	1	0.6	0	0.0			
BMI ≥ 30	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Yes	37	22.2	27	32.1	-10.0	-21.8	1.8
No	130	77.8	57	67.9			
Tegner Activity (pre-injury)	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Active (>4)	132	79.0	61	72.6	6.4	-4.9	17.8
Non-Active (≤4)	35	21.0	23	27.4			
Age Category							
≥50	40	24.0	34	40.5			
<50	127	76.0	50	59.5			
Age Group	**n**	**%**	**n**	**%**	**p[2]**		
21-<45 (Young adulthood)	94	56.3	41	48.8	0.533		
45-<65 (Middle adulthood)	68	40.7	40	47.6			
≥65 (Elderly)	5	3.0	3	3.6			
Site Location	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
US	33	19.8	18	21.4	-1.7	-12.3	9.0
OUS	134	80.2	66	78.6			
Smoking History	**n**	**%**	**n**	**%**	**p[2]**		
Current[3]	37	22.2	22	26.2	0.191		
Past	22	13.2	17	20.2			
Never	108	64.7	45	53.6			

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.
[2] P-value for Chi-Square test.
[3] Includes 2 Agili-C™ subjects and 1 SSOC subject who quit smoking within 6 months of index procedure.

The treatment groups had similar lesion characteristics (see **Table 6** and **Table 7**) with only minor differences that would not have biased the study in favor of the Agili-C™ group. The percentage of subjects with large lesions (defined as total lesion area > 3 cm^2) was larger in subjects randomized to Agili-C™ compared to SSOC (58.7% vs 48.8%). This was also reflected in the total lesion size (**Table 7**), where the total lesion size was larger in subjects randomized to Agili-C™ compared to SSOC (3.9cm^2 vs 3.4cm^2). Similarly, the percentage of subjects with osteochondral lesions (ICRS grade 4B) was higher in subjects randomized to Agili-C™ compared to SSOC (37.7% vs 19.0%). Additionally, the percentage of subjects with multiple lesions was higher in subjects randomized to Agili-C™ compared to SSOC (34.7% vs 31.0%). In contrast the percentage of subjects with mild/moderate osteoarthritis (K/L grades 2-3) was smaller in

subjects randomized to Agili-C™ compared to SSOC (45.5% vs 64.3%). Overall, while there were some differences between groups, the degree of overall severity was similar. Subgroup analyses for lesion size, lesion type, and level of osteoarthritis demonstrate that these minor differences in lesion characteristics did not affect the study results.

Table 6. Categorical Lesion Characteristics – Safety Analysis Set

	Agili-C™		SSOC		Agili-C™ - SSOC[1]		
Kellgren-Lawrence Grade	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
None	91	54.5	30	35.7	18.8	6.0	31.5
Mild/Moderate	76	45.5	54	64.3			
Lesion Size >3 cm²	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Yes	98	58.7	41	48.8	9.9	-3.2	22.9
No	69	41.3	43	51.2			
Single vs Multiple Lesions	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Single	109	65.3	58	69.0	-3.8	-16.0	8.5
Multiple	58	34.7	26	31.0			
ICRS Grade (worst across lesions)	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Osteochondral lesions (ICRS 4b)	63	37.7	16	19.0	18.7	7.5	29.8
Chondral lesions (ICRS 3 & 4a)	104	62.3	68	81.0	.	.	.

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences

Table 7. Continuous Lesion Variables – Safety Analysis Set

	Agili-C™						SSOC						Agili-C™ - SSOC[1]		
	N	**Mean**	**SD**	**Med**	**Min**	**Max**	**N**	**Mean**	**SD**	**Med**	**Min**	**Max**	**Diff**	**LB**	**UB**
Sum of lesion areas (1, 2 + 3)	167	3.9	2.0	3.8	1.0	7.0	84	3.4	1.9	3.0	1.0	7.0	0.53	0.01	1.05
Lesion Area 1	167	2.9	1.6	2.3	1.0	7.0	84	2.6	1.6	2.2	0.1	7.0	0.27	-0.15	0.70
Lesion Area 2	58	2.7	1.5	3.0	0.5	6.0	26	2.1	1.1	1.9	0.8	4.5	0.64	-0.03	1.30
Lesion Area 3	6	2.7	1.2	2.3	1.5	5.0	5	2.3	1.3	2.5	1.0	4.0	0.39	-1.29	2.08

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.

Table 8. History of and Concomitant Treatments – Safety Analysis Set

	Agili-C™		SSOC		Agili-C™ - SSOC[1]		
Hx of ACL Repair (Intra/Extra articular)	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Yes	13	7.8	7	8.3	-0.5	-7.7	6.6
No	154	92.2	77	91.7	.	.	.
Hx of meniscectomy (medial/lateral)	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Yes	36	21.6	22	26.2	-4.6	-15.9	6.6
No	131	78.4	62	73.8	.	.	.
Concomitant meniscectomy (medial/lateral)	**n**	**%**	**n**	**%**	**Diff (%)**	**LB**	**UB**
Yes	50	29.9	19	22.6	7.3	-4.0	18.6
No	117	70.1	65	77.4	.	.	.
Meniscus Status	**n**	**%**	**n**	**%**	**p-value[2]**		
Intact	94	56.3	44	52.4	0.072		
History (partial)	23	13.8	21	25.0	.		
Concomitant	50	29.9	19	22.6	.		

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.
[2] P-value for Chi-Square test

SAFETY AND EFFECTIVENESS RESULTS

SAFETY SUMMARY

Agili-C™ demonstrated a favorable safety profile in the pivotal study compared to the SSOC. Importantly, among the pre-specified adverse events summarized below in **Table 10** occurred in 23.4% of Agili-C™ patients in the pivotal study, compared to 50.0% of SSOC patients. Moreover, as shown in **Figure 2**, the rates of any AE, serious AE, and treatment failure were lower in Agili-C™ compared to SSOC.

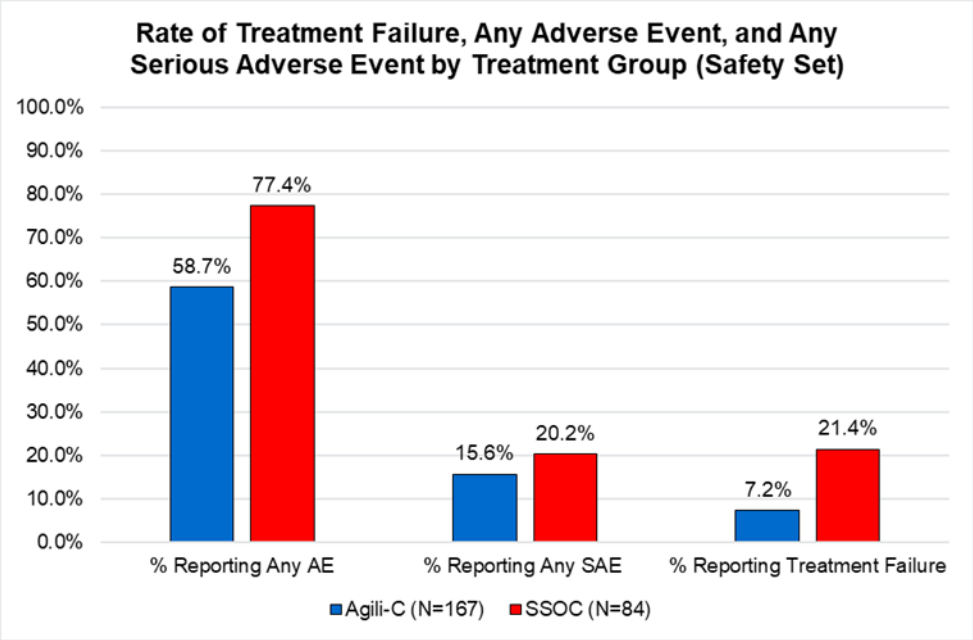


Figure 2: Rate of Any Adverse Event, Any Serious Adverse Event, and Treatment Failure by Treatment Group (Safety Set)

SAFETY RESULTS

The analysis of safety was based on the Safety Cohort of 251 total subjects treated (167 randomized and treated Agili-C™ subjects, and 84 SSOC Subjects).

The overall adverse event rate was less for the Agili-C™ Group (58.7%) compared to the SSOC group (77.4%).

At least one Severe AE was present in 9.6% of the Agili-C™ subjects compared to 20.2% in SSOC subject, and at least one Serious AE was present in 15.6% of the Agili-C™ subjects compared to 20.2% in SSOC subjects. Overall, AE rates were lower for Agili-C™ subjects compared to SSOC subjects, supporting a very favorable safety profile for Agili-C™.

CartiHeal

Table 9. Summary of Adverse Events (AEs) By Treatment Group As Treated (Safety) Analysis Set

	Agili-C™ N= 167		SSOC N= 84		Comparison		
Number (%) of Patients	**n**	**%**	**n**	**%**	**Diff.**	**95% LB**	**95% UB**
With no AEs	68	40.7%	19	22.6%	18.1	6.5	29.7
With one or more AE§	99	59.3%	65	77.4%	-18.1	-29.7	-6.5
With one or more Serious AEs	27	16.2%	17	20.2%	-4.1	-14.3	6.2
- With one or more serious device/toolset-related AEs	3	1.8%	--	--	--	--	--
- With one or more serious procedure-related AEs	4	2.4%	5	6.0%	-3.6	-9.1	2.0
With one or more device/toolset OR procedure-related* AEs	28	16.8%	23	27.4%	-10.6	-21.7	0.5
- With one or more device/toolset-related* AEs	5	3.0%	--	--	--	--	--
- With one or more procedure-related* AEs	23	13.8%	23	27.4%	-13.6	-24.5	-2.7
With one or more severe AEs	17	10.2%	17	20.2%	-10.1	-19.8	-0.3
With one or more moderate or severe AEs	79	47.3%	52	61.9%	-14.6	-27.5	-1.7
AE with outcome of death	0	0.0%	0	0.0%			
AE with outcome of device/toolset-related death	0	0.0%	--	--	--	--	--
Treatment Failure (Surgery or Injection)	12	7.2%	18	21.4%	-14.2	-23.9	-4.6

Notes:
§AEs included with onset date on or before the Month 24 visit date (if missing, end-of-study date) or Day 730, whichever is later.
*Related is defined as definitely or probably related.

Table 10. Incidence Rates (%) and Event Counts of AEs by System Organ Class and Preferred Term, Safety Analysis Set

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
PRE-SPECIFIED	39	23.4%	42	42	50.0%	48	-26.6	-39.1	-14.2
Decreased range of motion compared to baseline	2	1.2%	2	1	1.2%	1	0.0		
Deep vein thrombosis (dvt) and related complications				1	1.2%	1			
Increased swelling (or effusion) in the operated joint, compared to baseline	9	5.4%	9	4	4.8%	4	0.6	-5.1	6.3
Increased transient or chronic pain in the operated joint, compared to baseline	25	15.0%	25	33	39.3%	37	-24.3	-36.1	-12.6
Infection (including septicemia or deep infections in the operated joint) and related symptoms, such as fever and/or pus	1	0.6%	1						
Joint locking	1	0.6%	1						
Muscle atrophy compared to baseline	2	1.2%	2						
Progression of osteoarthritis (degeneration of surrounding bone and cartilage or delamination) compared to baseline				4	4.8%	4			
Wound complications (wound dehiscence, hematoma, site drainage or superficial infection)	2	1.2%	2	1	1.2%	1	0.0		
PREGNANCY, PUERPERIUM AND PERINATAL CONDITIONS	1	0.6%	1						
Foetal hypokinesia	1	0.6%	1						
CARDIAC DISORDERS				1	1.2%	1			
Coronary artery disease				1	1.2%	1			
CONGENITAL, FAMILIAL AND GENETIC DISORDERS				1	1.2%	1			
Arteriovenous malformation				1	1.2%	1			
EAR AND LABYRINTH DISORDER	1	0.6%	1						
Conductive deafness	1	0.6%	1						

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
ENDOCRINE DISORDERS	1	0.6%	1						
Hypothyroidism	1	0.6%	1						
EYE DISORDERS	3	1.8%	3						
Eye irritation	1	0.6%	1						
Retinal vein occlusion	1	0.6%	1						
Vision blurred	1	0.6%	1						
GASTROINTESTINAL DISORDERS	6	3.6%	6	2	2.4%	2	1.2		
Abdominal pain upper	1	0.6%	1						
Anal fistula				1	1.2%	1			
Colitis ulcerative	1	0.6%	1						
Constipation	1	0.6%	1						
Crohn's disease				1	1.2%	1			
Gastroesophageal reflux disease	1	0.6%	1						
Inguinal hernia	1	0.6%	1						
Umbilical hernia	1	0.6%	1						
GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS	2	1.2%	2	2	2.4%	2	-1.2		
Adverse drug reaction				1	1.2%	1			
Asthenia	1	0.6%	1						
Chest pain				1	1.2%	1			
Thermal burn	1	0.6%	1						
IMMUNE SYSTEM DISORDERS	4	2.4%	4	1	1.2%	1	1.2		
Allergy to metals	1	0.6%	1						
Drug hypersensitivity	3	1.8%	3	1	1.2%	1	0.6		
INFECTIONS AND INFESTATIONS	17	10.2%	18	8	9.5%	8	0.7	-7.1	8.4
COVID-19	6	3.6%	6	2	2.4%	2	1.2		
Coxsackie viral infection				1	1.2%	1			
Diverticulitis	1	0.6%	1						
Ear infection fungal	1	0.6%	1						
Gastroenteritis	1	0.6%	1						
Influenza	1	0.6%	1						
Nasopharyngitis	1	0.6%	1						
Orchitis	1	0.6%	1						
Otitis media	1	0.6%	1	1	1.2%	1	-0.6		
Pharyngitis streptococcal	1	0.6%	1	1	1.2%	1	-0.6		
Pneumonia	1	0.6%	1	1	1.2%	1	-0.6		
Stitch abscess	1	0.6%	1						
Tooth abscess	1	0.6%	1						
Tooth infection				1	1.2%	1			
Upper respiratory tract infection	1	0.6%	1	1	1.2%	1	-0.6		
INJURY, POISONING AND PROCEDURAL COMPLICATIONS	23	13.8%	25	12	14.3%	15	-0.5	-9.6	8.6
Animal bite	1	0.6%	1						
Cartilage injury				1	1.2%	1			
Chemical burns of eye				1	1.2%	1			
Contusion	5	3.0%	5	3	3.6%	3	-0.6	-5.3	4.2
Facial bones fracture	1	0.6%	1						
Hand fracture	1	0.6%	1						
Head injury	1	0.6%	1						
Iatrogenic injury	1	0.6%	1						
Iliotibial band syndrome	2	1.2%	2	1	1.2%	1	0.0		
Inadequate osteointegration	1	0.6%	1						
Injury	1	0.6%	1						
Ligament sprain	1	0.6%	1						

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
Limb injury				1	1.2%	1			
Meniscus injury				1	1.2%	1			
Muscle rupture	1	0.6%	1						
Muscle strain	1	0.6%	1						
Nerve injury				1	1.2%	1			
Post procedural haematoma	1	0.6%	1						
Post-traumatic neck syndrome	1	0.6%	1	1	1.2%	1	-0.6		
Procedural pain	1	0.6%	1						
Repetitive strain injury	1	0.6%	1						
Rib fracture				1	1.2%	1			
Road traffic accident				2	2.4%	2			
Sciatic nerve injury				1	1.2%	1			
Tendon rupture	1	0.6%	1	1	1.2%	1	-0.6		
Tooth fracture	1	0.6%	1						
Traumatic arthropathy	1	0.6%	1						
Wrist fracture	1	0.6%	1						
METABOLISM AND NUTRITION DISORDERS	3	1.8%	3						
Hyperlipidaemia	1	0.6%	1						
Obesity	1	0.6%	1						
Type 2 diabetes mellitus	1	0.6%	1						
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	35	21.0%	43	20	23.8%	22	-2.9	-13.9	8.2
Arthralgia	15	9.0%	16	10	11.9%	11	-2.9	-11.1	5.2
Back pain	2	1.2%	2	2	2.4%	2	-1.2		
Bursitis	1	0.6%	1						
Chondropathy	1	0.6%	1						
Foot deformity	1	0.6%	1						
Haemarthrosis	3	1.8%	3	1	1.2%	1	0.6		
Intervertebral disc degeneration				2	2.4%	2			
Intervertebral disc disorder				1	1.2%	1			
Joint effusion	1	0.6%	1						
Joint instability	1	0.6%	1						
Joint swelling	1	0.6%	1						
Musculoskeletal stiffness	1	0.6%	1						
Osteoarthritis	3	1.8%	3	1	1.2%	1	0.6		
Osteochondrosis	1	0.6%	1	1	1.2%	1	-0.6		
Pain in extremity	2	1.2%	2						
Plantar fasciitis	1	0.6%	1						
Rotator cuff syndrome	1	0.6%	1						
Spinal osteoarthritis				1	1.2%	1			
Spinal synovial cyst				1	1.2%	1			
Spondylolisthesis	1	0.6%	1						
Temporomandibular joint syndrome	1	0.6%	1						
Tendon disorder	3	1.8%	3						
Tendonitis	2	1.2%	2	1	1.2%	1	0.0		
NEOPLASMS BENIGN, MALIGNANT AND UNSPECIFIED (INCL CYSTS AND POLYPS)	1	0.6%	1	2	2.4%	2	-1.8		
Choroid neoplasm				1	1.2%	1			
Colon adenoma				1	1.2%	1			
Neuroma	1	0.6%	1						
NERVOUS SYSTEM DISORDERS	15	9.0%	15	5	6.0%	5	3.0	-3.6	9.7
Cervical radiculopathy	2	1.2%	2						
Migraine without aura				1	1.2%	1			
Post-traumatic headache				1	1.2%	1			

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
Sciatica	11	6.6%	11	3	3.6%	3	3.0	-2.5	8.5
Syncope	1	0.6%	1						
Thoracic outlet syndrome	1	0.6%	1						
PRODUCT ISSUES	1	0.6%	1						
Breast implant rupture	1	0.6%	1						
PSYCHIATRIC DISORDERS	1	0.6%	1	2	2.4%	2	-1.8		
Anxiety				1	1.2%	1			
Claustrophobia				1	1.2%	1			
Depression	1	0.6%	1						
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	5	3.0%	5	1	1.2%	1	1.2		
Menometrorrhagia	1	0.6%	1	1	1.2%	1	-0.6		
Menopausal symptoms	1	0.6%	1						
Penile discharge	1	0.6%	1						
Prostatism	1	0.6%	1						
Vaginal haemorrhage	1	0.6%	1						
RESPIRATORY, THORACIC AND MEDIASTINAL DISORDERS	3	1.8%	3	2	2.4%	2	-0.6		
Acute respiratory failure	1	0.6%	1						
Bronchiectasis				1	1.2%	1			
Dyspnoea	1	0.6%	1						
Pulmonary fibrosis				1	1.2%	1			
Sinusitis	1	0.6%	1						
SKIN AND SUBCUTANEOUS TISSUE DISORDERS	3	1.8%	3						
Dermatitis contact	1	0.6%	1						
Rash	1	0.6%	1						
Urticaria	1	0.6%	1						
SURGICAL AND MEDICAL PROCEDURES	1	0.6%	1	1	1.2%	1	-0.6		
Ligament operation	1	0.6%	1	1	1.2%	1	-0.6		
VASCULAR DISORDERS	4	2.4%	4						
Lymphoedema	1	0.6%	1						
Thrombophlebitis	1	0.6%	1						
Thrombosis	1	0.6%	1						
Varicose vein	1	0.6%	1						

Notes:
‡95% confidence intervals are provided when at least 3 subjects in both groups experienced the event. 95% confidence intervals that include 0.0 indicate that the observed treatment difference is consistent with chance variation.
§AEs included with onset date on or before the Month 24 visit date (if missing, end-of-study date) or Day 730, whichever is later.

Table 11 presents the incidence rates and events counts of severe AEs. Across all categories, group differences were in favor of Agili-C™, further supporting the device's safety profile.

Table 11. Incidence Rates (%) and Events Counts of Severe AEs by System Organ Class and Pre-specified or Preferred Term, Safety Analysis Set

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
PRE-SPECIFIED	1	0.6%	1	10	11.9%	10	-11.3		
Deep vein thrombosis (dvt) and related complications				1	1.2%	1			
Increased transient or chronic pain in the operated joint, compared to baseline	1	0.6%	1	7	8.3%	7	-7.7		

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
Progression of osteoarthritis (degeneration of surrounding bone and cartilage or delamination) compared to baseline				2	2.4%	2			
PREGNANCY, PUERPERIUM AND PERINATAL CONDITIONS	1	0.6%	1						
Foetal hypokinesia	1	0.6%	1						
CARDIAC DISORDERS				1	1.2%	1			
Coronary artery disease				1	1.2%	1			
IMMUNE SYSTEM DISORDERS	1	0.6%	1						
Allergy to metals	1	0.6%	1						
INFECTIONS AND INFESTATIONS	3	1.8%	3	1	1.2%	1	0.6		
COVID-19	3	1.8%	3	1	1.2%	1	0.6		
INJURY, POISONING AND PROCEDURAL COMPLICATIONS	3	1.8%	3	3	3.6%	3	-1.8	-6.2	2.7
Injury	1	0.6%	1						
Meniscus injury				1	1.2%	1			
Nerve injury				1	1.2%	1			
Post procedural haematoma	1	0.6%	1						
Tendon rupture	1	0.6%	1	1	1.2%	1	-0.6		
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	5	3.0%	5	3	3.6%	3	-0.6	-5.3	4.2
Arthralgia	1	0.6%	1	1	1.2%	1	-0.6		
Haemarthrosis	1	0.6%	1						
Intervertebral disc degeneration				1	1.2%	1			
Osteoarthritis	1	0.6%	1						
Osteochondrosis	1	0.6%	1						
Rotator cuff syndrome	1	0.6%	1						
Spinal synovial cyst				1	1.2%	1			
NEOPLASMS BENIGN, MALIGNANT AND UNSPECIFIED (INCL CYSTS AND POLYPS)				1	1.2%	1			
Choroid neoplasm				1	1.2%	1			
NERVOUS SYSTEM DISORDERS	1	0.6%	1						
Sciatica	1	0.6%	1						
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	1	0.6%	1	1	1.2%	1			
Menometrorrhagia				1	1.2%	1			
Vaginal haemorrhage	1	0.6%	1						
RESPIRATORY, THORACIC AND MEDIASTINAL DISORDERS	2	1.2%	2						
Acute respiratory failure	1	0.6%	1						
Dyspnoea	1	0.6%	1						
SURGICAL AND MEDICAL PROCEDURES	1	0.6%	1	1	1.2%	1	-0.6		
Ligament operation	1	0.6%	1	1	1.2%	1	-0.6		

Notes:
‡95% confidence intervals are provided when at least 3 subjects in both groups experienced the event. 95% confidence intervals that include 0.0 indicate that the observed treatment difference is consistent with chance variation.
§AEs included with onset date on or before the Month 24 visit date (if missing, end-of-study date) or Day 730, whichever is later.

Table 12 presents the incidence rates and event counts of serious AEs. Importantly, all group differences were negative (favoring Agili-C™) or similar between groups, further supporting the favorable safety profile of Agili-C™.

The most common serious AEs in the Agili-C™ group were COVID-19 (n=4, 2.4%), contusion (n=3, 1.8%), "increased transient or chronic pain in the operated joint, compared to baseline" (n=2, 1.2%), and arthralgia (n=2, 1.2%). The rate of "increased transient or chronic pain in the operated joint, compared to baseline" was substantially lower in the Agili-C™ arm compared to the SSOC group (n=7, 8.3%).

There were no unanticipated serious adverse device effects (USADEs).

Table 12. Incidence Rates (%) and Event Counts of Serious AEs by System Organ Class and Pre-specified or Preferred Term Safety Analysis Set

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
PRE-SPECIFIED	4	2.4%	4	10	11.9%	10	-9.5	-16.8	-2.2
Decreased range of motion compared to baseline	1	0.6%	1						
Deep vein thrombosis (dvt) and related complications				1	1.2%	1			
Increased transient or chronic pain in the operated joint, compared to baseline	2	1.2%	2	7	8.3%	7	-7.1		
Infection (including septicemia or deep infections in the operated joint) and related symptoms, such as fever and/or pus	1	0.6%	1						
Progression of osteoarthritis (degeneration of surrounding bone and cartilage or delamination) compared to baseline				2	2.4%	2			
PREGNANCY, PUERPERIUM AND PERINATAL CONDITIONS	1	0.6%	1						
Foetal hypokinesia	1	0.6%	1						
CARDIAC DISORDERS				1	1.2%	1			
Coronary artery disease				1	1.2%	1			
EAR AND LABYRINTH DISORDER	1	0.6%	1						
Conductive deafness	1	0.6%	1						
GENERAL DISORDERS AND ADMINISTRATION SITE CONDITIONS	1	0.6%	1						
Asthenia	1	0.6%	1						
IMMUNE SYSTEM DISORDERS	1	0.6%	1						
Allergy to metals	1	0.6%	1						
INFECTIONS AND INFESTATIONS	4	2.4%	4	1	1.2%	1	1.2		
COVID-19	4	2.4%	4	1	1.2%	1	1.2		
INJURY, POISONING AND PROCEDURAL COMPLICATIONS	7	4.2%	7	4	4.8%	4	-0.6	-6.0	4.9
Cartilage Injury				1	1.2%	1			
Contusion	3	1.8%	3						
Injury	1	0.6%	1						
Meniscus Injury				1	1.2%	1			
Nerve Injury				1	1.2%	1			
Post Procedural Haematoma	1	0.6%	1						
Tendon Rupture	1	0.6%	1	1	1.2%	1	-0.6		
Traumatic Arthropathy	1	0.6%	1						
MUSCULOSKELETAL AND CONNECTIVE TISSUE DISORDERS	5	3.0%	5	2	2.4%	2	0.6		
Athralgia	2	1.2%	2						
Intervertebral Disc Degeneration				1	1.2%	1			
Osteoarthritis	1	0.6%	1						
Osteochondrosis	1	0.6%	1						
Rotator Cuff Syndrome	1	0.6%	1						
Spinal Synovial Cyst				1	1.2%	1			
NEOPLASMS BENIGN, MALIGNANT AND UNSPECIFIED (INCL CYSTS AND POLYPS)				1	1.2%	1			
Choroid neoplasm				1	1.2%	1			
NERVOUS SYSTEM DISORDERS	1	0.6%	1						
Sciatica	1	0.6%	1						
PRODUCT ISSUES	1	0.6%	1						
Breast implant rupture	1	0.6%	1						

	Agili-C™ N= 167			SSOC N= 84			Comparison‡		
With one or more AE§	**n**	**%**	**Count**	**n**	**%**	**Count**	**Diff.**	**95% LB**	**95% UB**
REPRODUCTIVE SYSTEM AND BREAST DISORDERS	1	0.6%	1	1	1.2%	1	-0.6		
Menometrorrhagia				1	1.2%	1			
Vaginal haemorrhage	1	0.6%	1						
RESPIRATORY, THORACIC AND MEDIASTINAL DISORDERS	1	0.6%	1						
Acute respiratory failure	1	0.6%	1						
SURGICAL AND MEDICAL PROCEDURES	1	0.6%	1	1	1.2%	1	-0.6		
Ligament operation	1	0.6%	1	1	1.2%	1	-0.6		
VASCULAR DISORDERS	1	0.6%	1						
Thrombophlebitis	1	0.6%	1						

Notes:
‡95% confidence intervals are provided when at least 3 subjects in both groups experienced the event. 95% confidence intervals that include 0.0 indicate that the observed treatment difference is consistent with chance variation.
§AEs included with onset date on or before the Month 24 visit date (if missing, end-of-study date) or Day 730, whichever is later.

TREATMENT FAILURES

In the safety analysis set, 12 of 167 (7.2%) Agili-C™ subjects and 18 of 84 (21.4%) SSOC subjects experienced a treatment failure as defined in the protocol. The treatment group difference was statistically significant according to an unadjusted chi-square test (p=0.002). As indicated in **Table 13**, 4 of the treatment failures in Agili-C™ were due to knee trauma (0 in the SSOC), while 4 of the treatment failures in the SSOC were due to knee replacements and osteotomies (0 in the Agili-C™).

Among subjects with mild to moderate OA, 27.8% of the subjects in the SSOC group were treatment failures compared to 5.3% in the Agili-C™ arm. A similarly high failure rate was noted in SSOC subjects with large lesions (22.0% of the subjects), compared to 5.1% in the Agili-C™ arm.

Table 13. Main AE Term: Summary of Treatment Failures by Treatment Group, Safety Analysis Set

	All N= 251		Agili-C N= 167		SSOC N= 84		p-values‡
Treatment Failures	30	12.0%	12	7.2%	18	21.4%	0.002
Main AE term:							
- Increased transient or chronic pain (pre-specified)	19	7.6%	4	2.4%	15	17.9%	<0.001
- Progression of osteoarthritis (pre-specified)	2	0.8%	0	0.0%	2	2.4%	0.111
- Activity related knee pain (Other)	1	0.4%	0	0.0%	1	1.2%	0.335
- Knee trauma (Other)	4	1.6%	4	2.4%	0	0.0%	0.304
- ACL graft complications (Other)	2	0.8%	2	1.2%	0	0.0%	0.553
- New osteochondral lesion (Other)	1	0.4%	1	0.6%	0	0.0%	1.000
- Infection (pre-specified)	1	0.4%	1	0.6%	0	0.0%	1.000

Notes:
‡ Fisher's Exact tests

Table 14. AE Relatedness: Summary of Treatment Failures by Treatment Group, Safety Analysis Set

	All N= 251		Agili-C N= 167		SSOC N= 84		p-values‡
Treatment Failures	30	12.0%	12	7.2%	18	21.4%	0.002
AE Relatedness:							
- Related	6	2.4%	1	0.6%	5	6.0%	0.017
- Related to device and/or toolset	1	0.4%	1	0.6%	--	--	--
- Related to procedure	5	2.0%	0	0.0%	5	6.0%	0.004
- Probably related	8	3.2%	5	3.0%	3	3.6%	1.000
- Probably related to device and/or toolset	2	0.8%	2	1.2%	--	--	--
- Probably related to procedure	6	2.4%	3	1.8%	3	3.6%	0.405
- Possibly related	14	5.6%	4	2.4%	10	11.9%	0.006
- Possibly related to device and/or toolset	2	0.8%	2	1.2%	--	--	--
- Possibly related to procedure	12	4.8%	2	1.2%	10	11.9%	<0.001
- Unrelated	2	0.8%	2	1.2%	0	0.0%	0.553

Notes:
‡ Fisher's Exact tests

Device Removals

The rate of treatment failures was 21.4% (n=18) in the SSOC arm and only 7.2% (n=12) in the Agili-C™ arm. Among the 12 treatment failures in the Agili-C™ arm, 8 cases included a device removal (4.8%, 8/167). Of the 8 implant removal cases, 5 removals (representing 3% of the subjects in the study arm) occurred due to knee trauma or subjects overdoing exercise early in the post-implantation period.

EFFECTIVENESS SUMMARY

The Bayesian analysis results for KOOS Overall (primary endpoint) and the KOOS subscales (confirmatory secondary endpoints and secondary endpoints) at 24 Months are summarized below in **Figure 3**. Agili-C™'s performance was both statistically significant and clinically meaningful across all KOOS endpoints. As discussed in more detail below, results across the other secondary analyses, as well as sensitivity and covariate analyses, were similarly favorable. Thus, study success was established by meeting the primary endpoint and all secondary confirmatory endpoints, and was confirmed to be robust across several secondary analyses.

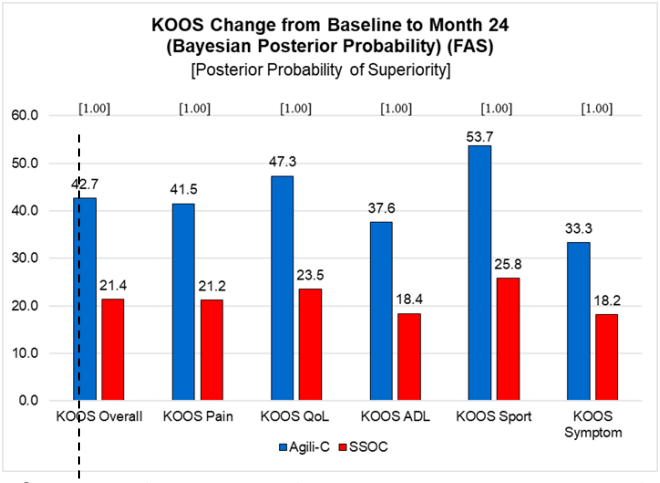


Figure 3: KOOS Change from Baseline to Month 24, Bayesian Posterior Probability (FAS) [Posterior Probability of Superiority]

EFFECTIVENESS RESULTS

The primary endpoint was assessed as the change from baseline to 24 months in the average KOOS Overall Score in the Full Analysis Set (FAS) to evaluate the superiority of the Agili-C™ compared to the SSOC. The mean of the posterior distribution for changes from baseline to Month 24 in the KOOS Overall Score for subjects randomized to Agili-C™ is 42.65 (39.55, 45.54). For subjects randomized to SSOC, the mean of the posterior distribution is 21.39 (17.35, 25.71). The mean (95% credible interval) of the posterior distribution for the group difference (Agili-C™ minus SSOC) in change from baseline to Month 24 in the KOOS Overall Score is 21.27 (16.17, 26.60) (**Table 15**).

Based on these results, the posterior probability of superiority was determined to be 1.000. Since 1.000 > 0.98, the null hypothesis is rejected, and these results demonstrate that the Agili-C™ is superior to SSOC in terms of improvements from baseline to Month 24 in KOOS Overall Score.

Table 15. Bayesian Posterior Probability of Month 24 Superior of Agili-C™ Relative to SSOC (FAS)

Parameter	N	Mean of Posterior Distribution	SD of Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority[2]
Agili-C™	5000	42.65	1.54	39.55	45.54	.
SSOC	5000	21.39	2.14	17.35	25.71	.
Agili-C™ - SSOC	5000	21.27	2.67	16.17	26.60	**1.000**

Notes:
[1]Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOCs.
[2]Posterior probability that the mean improvement is larger for Agili-C™ compared to SSOC.

An MMRM model was applied to changes in KOOS Overall Score over time for both the Agili-C™ and SSOC groups. The mean changes for each group and the group difference in mean changes (Agili-C™ minus SSOC) separately at every follow-up time period are provided in **Table 16**. The estimated group difference (95% CI) in mean changes from baseline to Month 24 is 21.35 (16.24, 26.47) and the treatment-by-visit interaction is statistically significant (p<0.0001) demonstrating the increasingly larger group differences in mean improvements over time.

Table 16. Mixed Model for Repeated Measures (MMRM) for Changes in Overall KOOS Score (FAS)

Agili-C				
Visit	**LS Mean Change**	**LB of 2-sided 95% CI**	**UB of 2-sided 95% CI**	**p-value[2]**
Month 6	27.46	24.85	30.07	<.0001
Month 12	33.93	31.07	36.78	<.0001
Month 18	39.20	36.34	42.07	<.0001
Month 24	42.67	39.71	45.63	<.0001
Test for Trend[3]				<.0001
Surgical Standard of Care (SSOC)				
Visit	**LS Mean Change**	**LB of 2-sided 95% CI**	**UB of 2-sided 95% CI**	**p-value[2]**
Month 6	19.93	16.23	23.62	<.0001
Month 12	21.75	17.73	25.77	<.0001
Month 18	21.49	17.46	25.52	<.0001
Month 24	21.32	17.15	25.49	<.0001
Test for Trend[3]				0.568

Agili-C™ minus SSOC				
Visit	LS Group Difference in Mean Change	LB of 2-sided 95% CI	UB of 2-sided 95% CI	p-value[2]
Month 6	7.54	3.01	12.06	0.0012
Month 12	12.18	7.24	17.11	<.0001
Month 18	17.71	12.76	22.65	<.0001
Month 24	21.35	16.24	26.47	<.0001
Visit by Group Interaction[4]				<.0001

Notes:
[1] Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOC.
[2] p-value for within treatment group mean changes.
[3] F-test for linear trend. The null hypothesis is that mean changes are constant over time.
[4] The visit by group interaction tests whether the group difference in mean changes varies over time.

The four pre-specified confirmatory secondary endpoints were:

- Change in KOOS Pain score from baseline to Month 24.
- Change in KOOS Quality of Life score from baseline to Month 24.
- Change in KOOS ADL score from baseline to Month 24.
- Response rate at Month 24 defined as an improvement in KOOS Overall Score $\geqslant$ 30.

The four confirmatory secondary endpoints were to be tested in a hierarchical manner in order to control the type 1 error rate. Each of these secondary endpoints requires a Bayesian posterior probability greater than 0.975 for declaring superiority. As shown in the summary table below Agili-C™ demonstrated superiority on each of the confirmatory secondary endpoints.

Table 17. Summary of Confirmatory Secondary Endpoint Results

Parameter	Mean of Difference in Posterior Distribution	SD of Difference in Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority
Pain	20.33	2.50	15.37	25.05	**1.000**
QoL	23.79	3.44	17.01	30.44	**1.000**
ADL	19.25	2.39	14.60	23.84	**1.000**
KOOS Overall ≥ 30	0.443	0.061	0.320	0.557	**1.000**

The results of the first confirmatory secondary endpoint, change in KOOS Pain score, from baseline to Month 24, are shown in **Table 18**. The mean posterior distribution (95% credible interval) for the group difference in KOOS Pain score change was 20.33 (15.37, 25.05). The posterior probability of superiority was 1.000, which is larger than the pre-specified 0.975. Therefore, the Agili-C™ is superior to SSOC from baseline to Month 24 in KOOS Pain score.

Table 18. Bayesian Posterior Probability of Month 24 Superiority Agili-C™ Relative to SSOC for Change from Baseline to Month 24 in KOOS Pain Score (FAS)

Parameter	N	Mean of Posterior Distribution	SD of Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority[2]
Agili-C™	5000	41.52	1.43	38.51	44.09	.
SSOC	5000	21.20	2.00	17.26	25.11	.
Agili-C™ - SSOC	5000	20.33	2.50	15.37	25.05	**1.000**

Parameter	N	Mean of Posterior Distribution	SD of Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority[2]
Notes: [1]Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOCs. [2]Posterior probability that the mean improvement is larger for Agili-C™ compared to SSOC.						

In general, the minimal clinically important difference (MCID), i.e., the smallest change score needed for the effect to be clinically relevant, for the KOOS Pain score is between 8-10.[3] The KOOS Pain score MCID has also been reported for cartilage restoration procedures (16.7)[4] high tibial osteotomy (15.4)[5] and total knee arthroplasty (13.5).[6] The KOOS Pain score change from baseline in the Agili-C™ group was 31.4±16.2 at 6 months, 36.0±17.2 at 12 months, 40.3±17.4 at 18 months, and 42.1±18.1 at 24 months. As the change in KOOS Pain score was substantially greater than the reported MCID values (approximately 4X the MCID by 24 months), these results demonstrate that patients receiving the Agili-C™ treatment experienced a substantial and clinically meaningful improvement in pain at each time point.

The mean posterior distribution group difference in KOOS QOL score change was 23.79 (17.01, 30.44). The posterior probability of superiority was 1.000, which is larger than the pre-specified 0.975. Therefore, the Agili-C™ is superior to SSOC from baseline to Month 24 in KOOS QOL score.

Table 19. Bayesian Posterior Probability of Month 24 Superiority Agili-C™ Relative to SSOC for Change from Baseline to Month 24 in KOOS QOL Score (FAS)

Parameter	N	Mean of Posterior Distribution	SD of Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority[2]
Agili-C™	5000	47.29	1.98	43.50	51.24	.
SSOC	5000	23.49	2.76	18.05	28.80	.
Agili-C™ - SSOC	5000	23.79	3.44	17.01	30.44	**1.000**
Notes: [1]Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOCs. [2]Posterior probability that the mean improvement is larger for Agili-C™ compared to SSOC.						

The MCID for the KOOS QOL score in general is between 8-10.[7] The KOOS QOL score MCID has also been reported for high tibial osteotomy (16.5)[8] and total knee arthroplasty (5.5).[9] The KOOS QOL score change from baseline in the Agili-C™ group was 26.4±25.3 at 6 months, 36.0±26.5 at 12 months, 42.4±27.2 at 18

3 http://www.koos.nu/koosfaq.html
4 Ogura T, Ackermann J, et al., The Minimal Clinically Important Difference and Substantial Clinical Benefit in the Patient-Reported Outcome Measures of Patients Undergoing Osteochondral Allograft Transplantation in the Knee, Cartilage. 2021 Jan;12(1):42-50.
5 Jacquet C, Pioger C, et al., Evaluation of the "Minimal Clinically Important Difference" (MCID) of the KOOS, KSS and SF-12 scores after open-wedge high tibial osteotomy, Knee Surg Sports Traumatol Arthrosc. 2021 Mar;29(3):820-826.
6 Eckhard L, Munir S, et al., Minimal important change and minimum clinically important difference values of the KOOS-12 after total knee arthroplasty, Knee. 2021 Mar;29:541-546.
7 http://www.koos.nu/koosfaq.html
8 Jacquet C, Pioger C, et al., Evaluation of the "Minimal Clinically Important Difference" (MCID) of the KOOS, KSS and SF-12 scores after open-wedge high tibial osteotomy, Knee Surg Sports Traumatol Arthrosc. 2021 Mar;29(3):820-826.
9 Eckhard L, Munir S, et al., Minimal important change and minimum clinically important difference values of the KOOS-12 after total knee arthroplasty, Knee. 2021 Mar;29:541-546.

months, and 47.5±27.1 at 24 months. As the change in KOOS QOL score was greater than the reported MCID, these results demonstrate that patients receiving the Agili-C™ treatment experienced a substantial, clinically meaningful improvement in quality of life at each time point.

The mean posterior distribution (95% credible interval) for the group difference in KOOS ADL score change was 19.25 (14.50, 23.84). The posterior probability of superiority was 1.000, which is larger than the pre-specified 0.975. Therefore, the Agili-C™ is superior to SSOC from baseline to Month 24 in KOOS ADL score.

Table 20. Bayesian Posterior Probability of Month 24 Superiority Agili-C™ Relative to SSOC for Change from Baseline to Month 24 in KOOS ADL Score (FAS)

Parameter	N	Mean of Posterior Distribution	SD of Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority[2]
Agili-C™	5000	37.59	1.37	34.94	40.29	.
SSOC	5000	18.35	1.92	14.62	22.12	.
Agili-C™ - SSOC	5000	19.25	2.39	14.60	23.84	**1.000**

Notes:
[1]Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOCs.
[2]Posterior probability that the mean improvement is larger for Agili-C™ compared to SSOC.

The MCID for the KOOS ADL score in general is between 8-10.[10] Furthermore, the KOOS ADL score MCID has been reported for high tibial osteotomy (17)[11] and total knee arthroplasty (13.7).[12] The KOOS ADL score change from baseline in the Agili-C™ group was 28.0±18.4 at 6 months, 31.6±19.9 at 12 months, 35.8±18.8 at 18 months, and 37.7±19.5 at 24 months. As the change in KOOS ADL score was greater than the MCID, these results demonstrate that patients receiving the Agili-C™ treatment experienced a substantial, clinically meaningful improvement in function during activities of daily living at each time point.

The mean posterior for the group difference in response rate was 0.443 (0.320, 0.557) (corresponding to a 77.8% response rate for Agili-C™ compared to only 33.6% for SSOC). These results demonstrate that patients treated with the Agili-C™ responded to treatment at significantly higher rate compared to SSOC indicating that the Further, the posterior probability of superiority was 1.000, which is larger than the pre-specified 0.975. Therefore, the Agili-C™ is superior to SSOC with regard to the overall KOOS responder rate.

Table 21. Bayesian Posterior Probability of Month 24 Superiority Agili-C™ Relative to SSOC for Increase from Baseline to Month 24 of ≥ 30 points on KOOS Overall Score (FAS)

Parameter[2]	N1[3]	N2[4]	Mean of Posterior Distribution	SD of Posterior Distribution	LB of Non-Parametric 95% CI	UB of Non-Parametric 95% CI	Posterior Probability of Superiority[5]

10 http://www.koos.nu/koosfaq.html
11 Jacquet C, Pioger C, et al., Evaluation of the "Minimal Clinically Important Difference" (MCID) of the KOOS, KSS and SF-12 scores after open-wedge high tibial osteotomy, Knee Surg Sports Traumatol Arthrosc. 2021 Mar;29(3):820-826.
12 Eckhard L, Munir S, et al., Minimal important change and minimum clinically important difference values of the KOOS-12 after total knee arthroplasty, Knee. 2021 Mar;29:541-546.

Agili-C™	20	5000	0.778	0.032	0.712	0.838	.
SSOC	20	5000	0.336	0.051	0.240	0.440	.
Agili-C™ - SSOC	20	5000	0.443	0.061	0.320	0.557	**1.000**

Notes:
[1]Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOCs.
[2]Statistics describing posterior distribution and posterior probability of superiority presented as mean across multiple imputations
[3]Number of Bayesian multiple imputations
[4]Number of random draws from posterior distribution for determining statistics under each multiple imputation
[5]Posterior probability that the mean improvement is larger for Agili-C™ compared to SSOC.

Additional secondary endpoints included:

- Percentage of articular defect fill according to MRI at 12 and 24 months
- Change from baseline in average overall KOOS score (Pain, Symptoms, QOL, ADL & Sports) at 6, 12, and 18 Months
- Change from baseline in IKDC Subjective Knee Evaluation[13] at 12, 18, and 24 Months
- Change from baseline in Tegner score[14] at 12, 18, and 24 Months
- Change from baseline QOL as measured by SF-12 v2[15] at 6, 12, 18, and 24 Months
- Change from baseline to 24 months in the average overall KOOS score (Pain, Symptoms, QOL, ADL & Sports) in:
    - patients with chondral lesions
    - patients with osteochondral lesions
    - patients with single lesion
    - patients with multiple lesions
    - patients without osteoarthritis (K/L 0-1)
    - patients with osteoarthritis (K/L 2-3)
    - patients with total lesion(s) size ≤3cm²
    - patients with total lesion(s) size >3cm²
    - patients without previous ligament reconstruction
    - patients with intact meniscus
    - patients with previous partial meniscectomy
    - patients with concomitant partial meniscectomy
    - active patients
    - non-active patients

Table 22 summarizes the percentages of defect fill, with MRI analyses performed at Month 12 and at Month 24. In order to preserve the ordinal nature of the categories, group comparisons were performed using a Wilcoxon rank sum test at each time point.

13 The FDA guidance document, *Preparation of IDEs and INDs for Products Intended to Repair or Replace Knee Cartilage* (Dec. 2011), lists the IKDC Subjective Knee Evaluation Form 2000 as a measure that may be used to assess efficacy in clinical studies of products intended to repair or replace knee cartilage.

14 Tegner Y, Lysholm J. Rating systems in the evaluation of knee ligament injuries. *Clin Orthop Relat Res.* 1985;198:43–9.

15 Ware J.E., Kosinski M., & Keller S.D., SF-12: How to Score the SF-12 Physical and Mental Health Summary Scales. 3rd ed. QualityMetric, Lincoln, RI 1998.

Table 22. Summary of MR Defect Fill at 12 and 24 Months (FAS)

	Agili-C™		SSOC		
Month 12 MRI Defect Fill (%)	**n**	**%**	**n**	**%**	**p-value[1]**
0-24	2	1.3	24	31.2	<0.0001
25-49	2	1.3	13	16.9	
50-74	16	10.1	14	18.2	
75-99	107	67.7	17	22.1	
100	31	19.6	9	11.7	
Month 24 MRI Defect Fill (%)					
0-24	0	0.0	22	32.4	<0.0001
25-49	2	1.3	12	17.6	
50-74	16	10.3	13	19.1	
75-99	95	60.9	14	20.6	
100	43	27.6	7	10.3	

Notes:
[1] P-value for Wilcoxon rank sum test

The results of the MRI defect fill demonstrated statistically significant (<0.0001) differences between treatment groups. At 24 Months 88.5% of subjects treated with Agili-C™ had at least 75% defect fill compared to only 30.9% among subjects treated with SSOC. Moreover, only 1.3% of the Agili-C™ subjects had less than 50% defect fill at 24 Months, compared to 50% in the SSOC group.

The change from baseline in the International Knee Documentation Committee (IKDC) was evaluated at 12, 18, and 24 months, as shown in **Table 23**. The group differences (95% CI) in mean change values increased from 12.0 (6.5, 17.5) at Month 12, to 16.3 (10.7, 21.9) at Month 18, and to 22.7 (16.8, 28.6) at Month 24.

Table 23. IKDC Knee Examination Change from Baseline (FAS)

	Agili-C™						SSOC						Agili-C™ - SSOC[1]		
	N	**Mean**	**SD**	**Med**	**Min**	**Max**	**N**	**Mean**	**SD**	**Med**	**Min**	**Max**	**Diff**	**LB**	**UB**
Month 6	164	24.0	18.8	24.7	-25.3	67.8	81	17.6	18.6	18.4	-29.9	60.9	6.4	1.4	11.4
Month 12	163	32.5	20.6	34.5	-17.2	80.5	80	20.5	20.3	21.3	-23.0	80.5	12.0	6.5	17.5
Month 18	162	38.1	20.8	41.4	-18.4	82.8	81	21.8	21.4	20.7	-20.7	86.2	16.3	10.7	21.9
Month 24	160	43.0	21.2	46.0	-13.8	82.8	79	20.3	23.0	19.5	-17.2	86.2	22.7	16.8	28.6

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.

The MCID for IKDC has been reported to be 16.7 at 12 months after articular cartilage repair surgeries.[16] As shown in the table above, the IKDC change from baseline in the Agili-C™ group was 24.0±18.8 at 6 months, 32.5±20.6 at 12 months, 38.1±20.8 at 18 months, and 43.0±21.2 at 24 months. These results show that the IKDC scores are substantially higher than the MCID at each timepoint, demonstrating that these patients reported clinically significant improvements in symptoms and function in daily living activities.[17] These results are consistent with the improvement in KOOS assessed as the primary endpoint.

16 Roos EM, Engelhart L, et al., Patient-Reported Outcome Instruments for Use in Patients with Articular Cartilage Defects, Cartilage. 2011 Apr; 2(2): 122–136.
17 Higgins LD, Taylor MK, et al., Reliability and validity of the International Knee Documentation Committee (IKDC) Subjective Knee Form, Joint Bone Spine. 2007 Dec; 74(6): 594-9.

The change from baseline in the Tegner Score was evaluated at 12, 18, and 24 months, as shown in **Table 24**. The Tegner Score is a patient reported outcome that provides a standardized method for determining the patient's level of activity before and after a knee injury.[18] The group differences (95% CI) in mean change values increased from 0.6 (0.1, 1.0) at Month 12, to 0.8 (0.4, 1.3) at Month 18, and to 1.5 (1.0, 1.9) at Month 24.

Table 24. Tegner Score Change from Baseline (FAS)

	Agili-C™						SSOC						Agili-C™ - SSOC[1]		
	N	Mean	SD	Med	Min	Max	N	Mean	SD	Med	Min	Max	Diff	LB	UB
Month 6	164	1.0	1.5	1.0	-3.0	5.0	81	0.8	1.5	0.0	-2.0	4.0	0.3	-0.1	0.7
Month 12	163	1.7	1.6	2.0	-2.0	8.0	81	1.1	1.7	1.0	-3.0	8.0	0.6	0.1	1.0
Month 18	161	2.0	1.8	2d.0	-1.0	8.0	81	1.2	1.8	1.0	-3.0	8.0	0.8	0.4	1.3
Month 24	160	2.5	1.7	2.0	0.0	8.0	79	1.0	1.6	1.0	-2.0	8.0	1.5	1.0	1.9

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.

These results are clinically meaningfully as each 1-unit increment of the Tegner scale represents a distinct class of functionality and activity level. For instance, both treatment arms began the study with a mean Tegner score of approximately 2.5, which correlates the ability to perform light work (e.g., walking on uneven ground, etc.). By Month 24 the Agili-C™ group improved by 2.5 points on average to a score of 5 on the Tegner scale. This indicates that Agili-C™ subjects, on average, could perform heavy labor and participate in competitive sports (e.g., soccer). By contrast, the SSOC control group improved by 1 point on average to a mean score of 3.5 on the Tegner scale. This indicates that control subjects, on average, were able to engage in moderately heavy labor (e.g., truck driving), but would not have improved to the point where they could participate in competitive sports or recreational sports (e.g., jogging). A return to recreational and competitive sports, as well as the option to engage in heavy labor, is a clinically relevant difference between the treatment groups in favor of the Agili-C.

The change from baseline to Month 24 in KOOS Sports score was also evaluated as shown in **Table 25**. The mean posterior distribution for the group difference in KOOS Sports score was 27.84 (20.69, 34.89). The posterior probability of superiority was 1.000, which is larger than the pre-specified 0.975. Therefore, the Agili-C™ is superior to SSOC from baseline to Month 24 in KOOS Sports score.

Table 25. Bayesian Posterior Probability of Month 24 Superiority Agili-C™ Relative to SSOC for Change from Baseline to Month 24 in KOOS Sports Score (FAS)

Parameter	N	Mean of Posterior Distribution	SD of Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority[2]
Agili-C™	5000	53.65	2.09	49.51	57.64	.
SSOC	5000	25.81	2.93	20.16	31.60	.
Agili-C™ - SSOC	5000	27.84	3.64	20.69	34.89	**1.000**

Notes:
[1]Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOCs.
[2]Posterior probability that the mean improvement is larger for Agili-C™ compared to SSOC.

18 https://www.apta.org/patient-care/evidence-based-practice-resources/test-measures/tegner-activity-scale

The MCID for the KOOS Sports score in general is between 8-10.[19] The KOOS Sports score MCID has also been reported for high tibial osteotomy (11.2)[20] and for cartilage restoration procedures (25).[21] As the change in KOOS Sports score was greater than the reported MCID at each time point, these results demonstrate that patients receiving the Agili-C™ treatment experienced a substantial, clinically meaningful improvement in physical function when active.

The change from baseline to Month 24 in KOOS Symptoms score was also evaluated as shown in **Table 26**. The mean posterior distribution for the group difference in KOOS Symptoms score was 15.15 (10.23, 19.87). The posterior probability of superiority was 1.000, which is larger than the pre-specified 0.975. Therefore, the Agili-C™ is superior to SSOC from baseline to Month 24 in KOOS Symptoms score.

Table 26. Bayesian Posterior Probability of Month 24 Superiority Agili-C™ Relative to SSOC for Change from Baseline to Month 24 in KOOS Other Symptoms Score (FAS)

Parameter	N	Mean of Posterior Distribution	SD of Posterior Distribution	LB of 95% HPD Interval	UB of 95% HPD Interval	Posterior Probability of Superiority[2]
Agili-C™	5000	33.30	1.43	30.59	36.15	.
SSOC	5000	18.15	2.00	14.21	22.06	.
Agili-C™ - SSOC	5000	15.15	2.49	10.23	19.87	**1.000**

Notes:
[1]Baseline observation carried forward after treatment failure for 11 Agili-C™ and 18 SSOCs.
[2]Posterior probability that the mean improvement is larger for Agili-C™ compared to SSOC.

The MCID for the KOOS Symptoms score in general is between 8-10.[22] The KOOS Symptoms score MCID has also been reported for high tibial osteotomy (15.1)[23] and for total knee arthroplasty (7).[24] As the change in KOOS Symptoms score was greater than the reported MCID at each time point, these results demonstrate that patients receiving the Agili-C™ treatment experienced a substantial, clinically meaningful improvement knee symptoms, including swelling, bending and straightening, and movement of the knee.

The group differences (95% CI) in mean change values of SF-12 Physical component were 2.8 (0.0, 5.6) at Month 6, 4.6 (1.8, 7.5) at Month 12, 6.9 (3.9, 9.8) at Month 18, and 7.8 (4.8, 10.8) at Month 24. The MCID for the SF-12 physical component has been reported as 1.8-4.3 after total knee arthroplasty procedures

19 http://www.koos.nu/koosfaq.html
20 Jacquet C, Pioger C, et al., Evaluation of the "Minimal Clinically Important Difference" (MCID) of the KOOS, KSS and SF-12 scores after open-wedge high tibial osteotomy, Knee Surg Sports Traumatol Arthrosc. 2021 Mar;29(3):820-826.
21 Ogura T, Ackermann J, et al., The Minimal Clinically Important Difference and Substantial Clinical Benefit in the Patient-Reported Outcome Measures of Patients Undergoing Osteochondral Allograft Transplantation in the Knee, Cartilage. 2021 Jan;12(1):42-50.
22 http://www.koos.nu/koosfaq.html
23 Jacquet C, Pioger C, et al., Evaluation of the "Minimal Clinically Important Difference" (MCID) of the KOOS, KSS and SF-12 scores after open-wedge high tibial osteotomy, Knee Surg Sports Traumatol Arthrosc. 2021 Mar;29(3):820-826.
24 Haydel A, Guilbeau S, et al., Achieving Validated Thresholds for Clinically Meaningful Change on the Knee Injury and Osteoarthritis Outcome Score After Total Knee Arthroplasty: Findings From a University-based Orthopaedic Tertiary Care Safety Net Practice, J Am Acad Orthop Surg Glob Res Rev. 2019 Nov 4;3(11):e00142.

at 12 months and 6.2-8.2 after autologous chondrocyte implantation procedures at 24 months[25]. These results show that the SF-12 physical component scores are higher than the control group by a MCID from 12 months and on, demonstrating that these patients reported clinically significant improvements in physical quality of life measurements, including general health, bodily pain, usual physical role activities, and physical functioning[26].

Table 27. Change from Baseline for the 12-item Short Form Survey (SF-12) Physical Component Score (FAS)

	Agili-C						SSOC						Agili-C™ - SSOC[1]		
	N	Mean	SD	Med	Min	Max	N	Mean	SD	Med	Min	Max	Diff	LB	UB
Month 6	164	10.2	10.3	8.6	-19.4	37.9	81	7.4	10.8	6.1	-13.0	33.5	2.8	0.0	5.6
Month 12	163	12.8	10.1	12.2	-10.2	39.1	81	8.2	11.7	5.0	-14.0	40.8	4.6	1.8	7.5
Month 18	162	14.9	10.5	16.0	-14.2	40.9	80	8.0	11.5	5.1	-20.6	40.8	6.9	3.9	9.8
Month 24	160	16.0	10.5	16.5	-14.3	37.3	79	8.2	12.0	7.5	-28.8	45.1	7.8	4.8	10.8

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.

The change from baseline in the SF-12 Mental Health Component was also evaluated at 6, 12, 18, and 24 months, as shown in **Table 28**. The group differences (95% CI) in mean change values were 2.8 (-0.3, 6.0) at Month 12, 2.7 (-0.7, 6.1) at Month 18, and 5.1 (1.8, 8.4) at Month 24 for the Mental Health Component score. As expected, there are no significant differences in the Mental Health Component score between the Agili-C™ and SSOC treatment groups.

Table 28. Change from Baseline for the 12-item Short Form Survey (SF-12) Mental Health Component Score (FAS)

	Agili-C						SSOC						Agili-C™ - SSOC[1]		
	N	Mean	SD	Med	Min	Max	N	Mean	SD	Med	Min	Max	Diff	LB	UB
Month 6	164	3.0	12.1	1.2	-34.9	37.1	81	1.0	12.9	-0.4	-30.7	39.8	2.0	-1.3	5.3
Month 12	163	4.3	11.9	1.8	-30.5	41.5	81	1.5	11.6	0.0	-20.0	40.3	2.8	-0.3	6.0
Month 18	162	4.3	13.1	2.3	-41.7	36.2	80	1.6	11.9	0.0	-20.3	40.3	2.7	-0.7	6.1
Month 24	160	5.5	12.5	2.5	-30.1	36.9	79	0.5	11.1	0.0	-26.8	37.3	5.1	1.8	8.4

Notes:
[1] Device group differences and 95% confidence intervals (CI) for group differences.

SUBGROUP AND COVARIATE ANALYSES

Preoperative demographic and clinical characteristics that could impact outcomes were evaluated using both subgroup analysis and covariate analysis. Subgroup analyses included variables such as lesion type,

25 Clement ND, Weir D, et al., Meaningful changes in the Short Form 12 physical and mental summary scores after total knee arthroplasty, Knee. 2019 Aug;26(4):861-868. doi: 10.1016/j.knee.2019.04.018; Clement ND, MacDonald D, et al., The minimal clinically important difference in the Oxford knee score and Short Form 12 score after total knee arthroplasty, Knee Surg Sports Traumatol Arthrosc. 2014 Aug;22(8):1933-9. doi: 10.1007/s00167-013-2776-5; Ogura T, Ackermann J, et al., Minimal Clinically Important Differences and Substantial Clinical Benefit in Patient-Reported Outcome Measures after Autologous Chondrocyte Implantation, Cartilage. 2020 Oct;11(4):412-422. doi: 10.1177/1947603518799839.

26 Ware J, Kosinski M, Keller S. SF-12: How to score the SF-12 Physical and Mental Summary Scales. 2nd ed. Boston, MA: The Health Institute, New England Medical Center; 1995.

number of lesions, level of osteoarthritis, lesion location, lesion size, previous ligament reconstruction, meniscus status, and activity status. Agili-C™'s superiority in effectiveness relative to standard of care was confirmed across all subgroups. Factors, such as subjects' activity level, status of ACL and meniscus, type of lesion, size of lesion, or number of lesions, which may be expected to negatively impact treatment outcomes due to challenging conditions, did not negatively impact the Agili-C™ superiority over the current SSOC.

In addition, covariate analysis was performed using covariates of age, sex, BMI, lesion type, number of lesions, level of OA, lesion size, ACL status, meniscus status, pre-injury activity status, smoking history, and lesion location. Consistent with the subgroup analysis, the covariate analysis demonstrated that factors that could be expected to negatively impact treatment outcomes due to more challenging conditions, such as a subject's activity level, BMI, status of ACL and meniscus, age, smoking history, and type, size, number, or location of lesions, did not negatively impact the Agili-C™ performance. The robustness of the data across many difficult to treat subgroups with consistent advantage for Agili-C™ over SSOC provides additional evidence of benefit and of the ability to use the device in a wide range of patients.

BENEFIT/RISK CONCLUSIONS

The risks presented by Agili-C™ are similar to or lower than those presented by existing surgical standard of care options (microfracture and debridement) for the same population. In the pivotal study, 58.7% of patients in the Agili-C™ arm experienced at least one adverse event (AE), compared to 77.4% of the subjects in the surgical standard of care (SSOC) group. The most common AE was increased transient chronic knee pain, which was present in 15.0% of the subjects in the Agili-C™ arm compared to 39.3% of the SSOC subjects. 9.6% of Agili-C™ subjects experienced at least one severe AE compared to 20.2% of SSOC subjects, and 15.6% of Agili-C™ subjects experienced at least one serious AE compared to 20.2% of SSOC subjects. Overall, AE rates were lower for Agili-C™ subjects compared to SSOC subjects, supporting a very favorable safety profile for Agili-C™. In the Safety Analysis Set of the pivotal study, a significantly higher rate of treatment failures was observed in the SSOC arm (21.4%) compared to the Agili-C™ arm (7.2%) (p=0.001).

Notably, none of these procedure-related risks were seen in the pivotal study. For the Agili-C™ group, there were 25 procedure-related adverse events (AEs), 4 of which were considered serious. This was similar to the SSOC group, which experienced 23 procedure-related AEs, 5 of which were serious.

Furthermore, although the SSOC procedures are conducted through minimally invasive arthroscopy procedures, the safety results from the pivotal study show that group differences are all negative, reflecting a favorable safety profile for the Agili-C™ implant and its related procedure. In several cases, the upper bound of the 95% confidence intervals are less than zero, suggesting a superior safety profile. Thus, as shown by the pivotal study, risks related to the Agili-C™ implantation procedure can be significantly mitigated by appropriate physician training and clear instructions for use (IFU).

Agili-C™ presents several benefits over current SSOC. In the pivotal study, the estimated mean improvement in KOOS Overall score was clinically and statistically significantly larger for Agili-C™

compared to SSOC starting at Month 6. The magnitude of the mean improvement increased over time for Agili-C™, but not for SSOC. At Month 24, the posterior mean for the treatment group improvement from baseline in the Agili-C™ arm was 42.7 compared to only 21.4 for the SSOC arm. The posterior mean of the difference in mean improvements was 21.3 (95% credible interval 16.2 to 26.6). A similar superiority margin was observed among subjects in the FAS with mild-moderate OA (Kellgren-Lawrence Grades of 2 or 3). The superiority margin increased to 27.3 with 95% credible interval of 20.5 to 33.9 for subjects with large lesions (total lesion areas larger than 3 cm^2). Results were very similar in the Per Protocol analysis set, which was identical to the FAS analysis set apart from excluding 1 participant randomized to Agili-C™.

Agili-C™'s superiority in effectiveness relative to standard of care was confirmed across all subgroups defined by pre-specified covariates. Factors such as subjects' activity level, BMI, status of ACL and meniscus, age, type of lesion, size of lesion or number of lesions – which could be expected to negatively impact treatment outcomes due to challenging conditions – did not negatively impact the Agili-C™ superiority over the current surgical standard of care, microfracture and debridement.

Therefore, the benefits of Agili-C™ outweigh the risks.

CONCLUSIONS DRAWN FROM THE STUDY DATA

The clinical data demonstrate the safety and effectiveness of Agili-C™ when used in accordance with the indications for use. All primary endpoints of the study were satisfied at 24 month follow-up intervals. Based on the clinical study results, the clinical benefits of the use of Agili-C™ outweigh the risks associated with the device and surgical procedure.

INSTRUCTIONS FOR USE

Please see the Surgical Technique Quick Guide for the complete set of instructions.

- Select suitable implant/s corresponding to the lesion dimensions.
- Select the correct tool size from the designated surgical tool set to match the desired implant dimensions.
- Check implant size, specifications and expiry date.
- Open the implant package carefully.
- Insert the implant gently and perpendicular into the implantation site in a pressed fit manner. Pay attention to the direction of the implant - the implant top has drilled channels. **The implant must be placed at least 2mm below the surface of the articular cartilage on all sides and fully surrounded by vital bone.**
- Multiple implants must not overlap. When multiple implants are used it is important to keep a bone bridge of at least **5 mm** between them to ensure the entire circumference of each implant is in direct contact with the bone.

PACKAGING

The Agili-C™ implant pre-packaged and sterile. It is intended for single use only. The implant is sterilized by gamma radiation using a minimum dose of 22.5kGy.

STORAGE CONDITIONS

Store the device in its sterile packaging at Room Temperature.

MRI SAFETY INFORMATION

The Agili-C™ is MR Safe.

CartiHeal
Atir Yeda 17, Kfar Saba, 4464313
Israel
Tel: +972 9 8810400 Fax: +972 9 8810401
info@cartiheal.com
www.cartiheal.com

Definition	Symbol
Lot/batch number:	
Catalogue number	REF
Use by/ Expiration date:	
See Instruction for use	
Single use only	
Do not re-sterilize	
By prescription only	
Do not use if package is damaged	
Manufacturer	

Patient Information Brochure

This brochure is written to help you make an informed decision about your surgery. Please read this entire brochure carefully. Keep this brochure. You may want to read it again. If you have additional questions, talk to your doctor. Only your doctor can determine the types of treatment that may be appropriate for you.

TABLE OF CONTENTS

GLOSSARY

Arthritis – Swelling (inflammation) of one or more of your joints. This can cause pain and stiffness that can worsen with age.

Articular Cartilage – A smooth, slippery, white tissue that covers the ends of bones at joints. Healthy cartilage in our joints makes it easier to move. It allows the bones to glide over each other with very little resistance. Articular cartilage can be damaged by injury or normal wear and tear.

Autologous Chondrocyte – A patient's own cartilage cells.

Degraded – Broken down by the body naturally.

Joint – The location where bones connect and bend.

Lesion – A tissue that has suffered damage through injury or disease.

Osteoarthritis ("OA") - A type of arthritis that occurs when flexible tissue at the ends of bones (cartilage) wears down. OA can cause pain, stiffness and swelling. OA is a disease that can limit motion over time.

Osteochondral Defect – An area of damage to both the cartilage and the underlying bone, due to trauma or osteoarthritis.

Osteonecrotic – Death of bone tissue

Osteoporosis – A disease that weakens bones

Subchondral Bone – This is the bone that sits directly below the Articular Cartilage.

WHAT IS THE AGILI-C™?

The Agili-C™ implant is made from Aragonite, a purified natural calcium carbonate derived from the inorganic parts of corals. Aragonite architecture has very similar properties to human cancellous bone. Due to these properties, the implant is designed to be integrated into your body over time. Then it is expected to be degraded while a new bone and cartilage will be formed instead of the implant.

Figure 1. Agili-C™ Implant

WHAT IS THE AGILI-C™ USED TO TREAT?

The Agili-C™ is intended to treat surface lesions of the knee, either to the cartilage or the cartilage and bone, caused either due to trauma or osteoarthritis (OA). The natural joint consists of two main tissues: articular cartilage and subchondral bone. Together they form the load-bearing system that allows the joint range of motion. Cartilage protects the subchondral bone from high stresses, absorbs shock, distributes load, facilitates stable motion within the joint and provides a self-lubricating surface. Unlike other tissues, cartilage is generally considered to have very limited capacity for self-repair. Defects and degeneration of the articular cartilage joint surfaces cause pain, joint swelling and stiffness; moreover, they can lead to premature joint degradation. Damage to the cartilage might be a result of a wide variety of causes such as physical injury, trauma, sports, disease and repetitive stress. Agili-C™ can be used to repair this damage before OA reaches severe stages.

HOW DOES AGILI-C™ TREAT SURFACE LESIONS IN THE KNEE?

In the surgical procedure, your surgeon will remove the damaged surface lesion which is causing pain. After removal of a cylinder of bone and cartilage, your surgeon will place the Agili-C™ implant in the created hole. The implant will be degraded by your body over time and replaced with your own tissue.

WHO SHOULD NOT RECEIVE THE AGILI-C™ ?

Agili-C™ should not be used if:

- You are hypersensitive, allergic, or intolerance of materials containing calcium or calcium-carbonate or coral. Tell your doctor if you have ever had an allergy to calcium, calcium-carbonate or coral. An allergic reaction after surgery could require your implant to be removed. Your doctor should not implant the device in you if you have ever had an allergic reaction to these materials.
- You have an infection in your knee, leg, or elsewhere in your body. An infection makes it risky to have knee surgery. Your doctor should not implant the device in you if you have an infection.
- You have any known tumor of the knee area.
- You were diagnosed with severe Osteoarthritis (OA)
- You have abnormal pain sensation in the joint or a severe blockage in the vessels of the legs
- You lack healthy bone wall or inappropriate bone thickness in the area of implantation that will not permit proper position of the implant.
- You have osteonecrotic bone or large "holes" at the bone under the cartilage (i.e. bone cysts) in the location of implantation
- You have a history of inflammatory joint disease or gout (crystalline deposits in your joints). Tell your doctor if you have gout. The Agili-C™ might not work in your joint if you have this type of condition.
- You have any bone disorders that may affect bone healing or wound healing. Tell your doctor if you have had any of the following conditions:
    - Cancer
    - Brittle bone or bone that breaks easily
    - You have a history of any growths (tumors) in your bones.

  These conditions might lead to changes in your bones that would prevent the Agili-C™ from working for you. You should talk to your doctor if you believe you have any of the above conditions or you are not sure whether you have any of the above conditions, before having surgery, so your doctor can help to determine whether Agili-C™ is right for you.

You should speak to your doctor to determine if the above conditions apply to you, or if other conditions may make you ineligible to use Agili-C™.

WHAT WARNINGS SHOULD I KNOW ABOUT WHEN THE AGILI-C™ IS USED?

Following surgery, your doctor will recommend rehabilitation for you. You should make sure to complete the rehabilitation as recommended.

Do not resume contact sports or other high-impact activities until your doctor advises that it is safe for you to do so. Early impact on the healing joint or severe knee trauma could cause your implant to break, which could cause pain and/or damage and may require additional surgery.

Consult your physician if you develop an infection, or if your knee join becomes painful, warm or sensitive to touch.

Tell your doctor if you are unable to comply with your doctor's recommended rehabilitation or refrain from contact sports or other high-impact activities for the recommended recovery period.

Tell your doctor if you are younger than 22 years old. The Agili-C™ device was not studied in people younger than 22 years old. The effect of the Agili-C™ device for these people is not known.

Agili-C™ has not been tested in pregnant or breast-feeding women.

Agili-C™ has not been tested in patients who have had chemotherapy.

Agili-C™ has not been tested in patients with osteoporosis.

Agili-C™ has not been tested for the treatment of cartilage and osteochondral defects on the patella or other joints.

WHAT ARE PRECAUTIONS RELATED TO THE USE OF THE AGILI-C™?

The Agili-C™ should only be used by an orthopedic surgeon who was trained in using the device and have experience performing knee surgery.

The Agili-C™ should not be exposed to extreme load bearing during your recuperation.

HOW HAVE WE TESTED AGILI-C™ IN CLINICAL TRIALS?

A controlled clinical study tested the Agili-C™. The study was done in hospitals in the United States Belgium, Italy, Israel, Hungary, Poland, Romania and Serbia. Patients had damaged surface lesions of the knee which were causing pain, similar to you. Study patients received the Agili-C™ or standard of care surgery (i.e. microfracture or debridement) in their knee. 251 patients were treated in this study. 167 subjects received the Agili-C™ implant and 84 patients had standard of care surgery. Patients were seen over a two-year period from surgery including a visit two years after surgery. Of the Agili-C™ patients, 163 patients of the 167 were available for the two-year visit and 77 of the 84 standard of care surgery were available at two years. The study results were reported to the U.S. Food and Drug Administration (FDA).

The study measured improvement in a score that incorporated pain, function, ability to do sports, and quality of life, rated on a 100-point scale. At two years after surgery, there was a 78% probability of getting at least 30 points better on this scale compared to baseline in the Agili-C™ group, compared to 34% in the standard of care surgery group.

WHAT PROBLEMS HAPPENED FROM AGILI-C™ SURGERY?

The Agili-C™ implant study followed patients for 2 years after surgery. The most common adverse events seen through 2 years after implant in the Agili-C™ patient group and the standard of care surgery group were as follows:

	Agili-C™ N= 167		Surgical Standard of Care N= 84	
Increased pain in the operated joint, compared to baseline	25	15.0%	33	39.3%
Pain in joint (arthralgia)	15	9.0%	10	11.9%
Increased swelling (or effusion) in the operated joint, compared to baseline	9	5.4%	4	4.8%
Worsening of osteoarthritis	0	0%	4	4.8%
Contusion (bruise)	5	3.0%	3	3.6%
Sciatica (pain affecting the back, hip, and outer side of the leg)	11	6.6%	3	3.6%

Events occurring in > 4% of the population in either group, whether or not related to the device or procedure.

The information above is based on the first 2 years after surgery. It is unknown what adverse events may develop after 2 years. It is also unknown how many subjects may develop them. In this study, we did not observe some adverse events we thought were possible. For example, although any surgical procedure can result in heart attack, stroke, or even death, but this was not observed in the Agili-C™ study, but these are possible complications of surgery.

The key risks related to the Agili-C™ implant and their rates of occurrence compared to standard of care surgery at the first two years are as follows:

Type of Event	Agili-C™ Group (N=167)	Surgical Standard of Care Group (N=84)
Treatment Failure	7.2%	21.4%
Device removal	4.8%	NA
Repeat surgery in operated knee	6.0%	7.1%
Conversion to total knee replacement	0%	4.8%
Knee injections	1.8%	17.9%
Infection and revision surgery	0.6%	0%

Please speak to your doctor immediately if you are experiencing any of these complications or if you feel you are experiencing symptoms that seem beyond post-operative healing, if you are sick to your stomach, have a fever, redness or rash, itching, tenderness or swelling of the operative knee.

HOW LONG CAN I EXPECT THE AGILI-C™ TO LAST?

The device is designed to provide a long-term treatment but is expected to be degraded and replaced by new tissue in about 12 months after placement. The effects of the surgery vary but in the clinical study, results at 24 months showed sustained benefit in many (but not all) patients. At two years, less than 5 in 100 patients (4.8%) had their implant removed.

ARE THERE ALTERNATIVES TO USING AGILI-C™?

There are several alternative treatments available for your knee condition that may relieve your symptoms:

- Articular cartilage stimulation: drilling or micro-fracture of the subchondral bone. These are surgeries designed to disrupt the subchondral bone to stimulate new tissue formation.
- Debridement: a surgical procedure designed to clean out the joint and remove tissue that may be torn or detached.
- Osteochondral autograft transfer: a surgery that involves harvesting tissue from minimal weight-bearing areas of another joint in your body and transplanting them to replace existing defects in weight-bearing areas of your knee.
- Osteochondral allograft transfer involves harvesting grafts from external donors (e.g., cadavers).
- Autologous chondrocyte implantation (ACI): involves placement of patient's cultured chondrocytes in the articular cartilage defect. The procedure requires two surgeries: one for the biopsy and a second for implantation.
- Joint arthroplasty: either a total or partial replacement of the knee joint with metal implants.

Your doctor will have more information on each of these options and other possible treatments, as well as the benefits and risks of each option. You should discuss these options with your doctor before surgery to decide what is the best treatment for you.

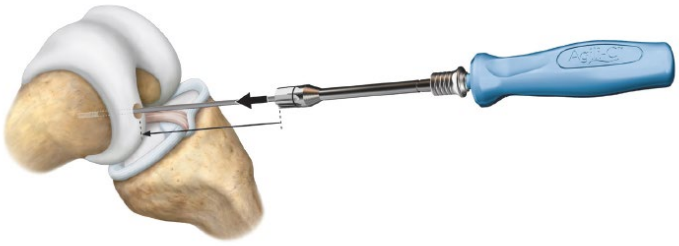
WHAT WILL HAPPEN BEFORE SURGERY?

Your doctor will give you instructions prior to your surgery. You should follow these instructions the day before the operation. This surgery usually occurs without an overnight stay in the hospital. The procedure usually lasts about 60 minutes.

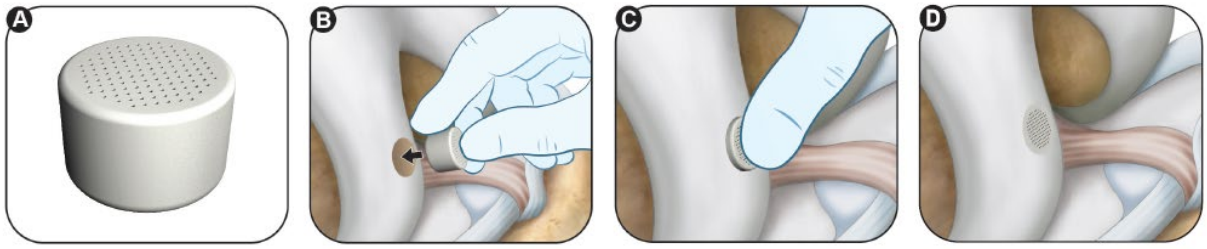
WHAT WILL HAPPEN DURING SURGERY?

The Agili-C™ goes through a cut in your knee. You will be given drugs that will numb the area and may put you to sleep during surgery.

First, your doctor will make a cut in the skin over your knee. This will open the joint of your knee. Then the doctor will use special tools to mark and remove soft tissue and bone to make a small hole for the implant. If needed multiple holes will be created for multiple implants.



Your doctor will then place the Agili-C™ into the hole.



The Agili-C™ stays in place without the use of cement or glue. Then, your doctor will close the cut in your knee with stitches.

WHAT CAN I EXPECT AFTER SURGERY?

Your doctor will provide you with specific recovery procedures that you should follow, that includes avoidance of high impact sports activities in the first 9-12 weeks after implantation. Following these steps will help ensure your chances of a successful surgery. You will need to limit your activity until you heal from the surgery, following your doctor's instructions before you resume weight bearing, and later activities such as sports. You will need to take time off from work and should not engage in contact sports or high impact activities until your doctor says it is safe for you to do so. You will need help from a physical therapist to recover fully from surgery. Be sure to ask your doctor if you have any questions regarding whether certain activities are permissible after surgery, as these directions will vary for each individual.

WHEN SHOULD I CALL MY DOCTOR?

Ask your doctor to describe how you will feel after surgery. Some pain and discomfort can be expected. Talk to your doctor about when to call with problems after surgery.

You should call your doctor immediately if you have intolerable pain, vomit, have a fever, or have any concerns with the appearance or sensations from your operative knee.

Additional information about the Agili-C™ can be found on the company's web site: www.cartiheal.com.

TALK TO YOUR DOCTOR

This pamphlet is meant to give you useful information and knowledge about the Agili-C™. It is not intended to replace medical advice or instruction from your doctor. Your doctor or physician is the only person responsible and qualified to appropriately diagnose and treat your health condition. Should you have any questions about the Agili-C™ or its relevance to your course of treatment, please call your doctor.

Agili-C™ is a prescription device limited to use by or on the order of a physician.

MRI SAFETY INFORMATION

The Agili-C™ is MR Safe.

CartiHeal
Atir Yeda 17, Kfar Saba, 4464313
Israel
Tel: +972 9 8810400 Fax: +972 9 8810401
info@cartiheal.com
www.cartiheal.com

Agili-C Surgical Toolset Cleaning/Reprocessing Instructions

CLEANING PROCEDURES

In point of use, keep soiled devices moist to prevent drying of soil and contaminants.

The surgical instruments and sterilization case tray should be thoroughly cleaned immediately after use. Prior to cleaning disassemble the Reamer / Shaper from the Quick Connect Handle:

Pay careful attention when cleaning devices with challenging design features. Challenging design features can include but are not limited to long cannulated instruments, instrument sockets.

DO NOT perform the cleaning procedure for Agili-C Surgical Toolset inside the Sterilization Case.

Manual Enzymatic Cleaning (for Tools and / or Sterilization Case):

1. Prepare a neutral / mild pH enzymatic detergent, according to the manufacturer's instructions (in the lowest recommended concentrations)
2. Soak the instruments in the detergent and scrub them with a soft brush, use a spiral pipe brush (3-4mm diameter) for cannulated areas, for at least two minutes. Pay special attention to areas where contamination might accumulate. Always avoid harsh materials that can scratch or mar the instruments surface.
3. Rinse the instruments thoroughly with deionized water following the cleaning process.
4. After cleaning, inspect the instruments to ensure that all visible contamination has been removed. Repeat cleaning if any contamination is visible.
5. Dry the instruments using a clean, soft cloth.

Automated Enzymatic Cleaning (for Tools and / or Sterilization Case):

1. Prepare a neutral/ mild pH enzymatic detergent, according to the manufacturer's instructions (in the lowest recommended concentrations).
2. Manual Pre-cleaning
    a. Follow the manual cleaning steps below prior to placing the instruments in the automatic washer.

   b. Immerse and soak for a minimum of one (1) minute in enzymatic detergent. Scrub them with a soft brush, use a spiral pipe brush (3-4mm diameter) for cannulated areas, for at least two minutes to remove visible contamination. Pay special attention to areas where contamination might accumulate. Always avoid harsh materials that can scratch or mar the instruments surface.
   c. Rinse thoroughly with deionized water.
3. Load the instruments in the washer such that the instruments are in full open position, accessible to cleaning and can drain (cannulated features/ holes positioned to drain).
4. Run the automatic wash cycle according to the following parameters:
   a. 3-minute cold prewash at 35±5˚C (95±41˚F)
   b. 5-minute cleaning wash with enzymatic agent at 60±5˚C (140±41˚F)
   c. 1-minute rinse with demineralized water at least 50˚C (122˚F)
   d. 3-minute thermal rinse at least 80˚C (176˚F)
   e. 6-minute drying phase at high temperature
5. After cleaning, inspect the instruments to ensure that all visible contamination has been removed and that the tools and sterilization case tray are visually clean. Repeat cleaning if any contamination is visible.

Manual Alkaline Cleaning - for Tools only, Do not perform on Sterilization Case:

1. Prepare an alkaline detergent, according to the manufacturer's instructions (in the lowest recommended concentrations).
2. Soak the instruments in the detergent and scrub them with a soft brush, use a spiral pipe brush (3-4mm diameter) for cannulated areas, for at least two minutes. Pay special attention to areas where contamination might accumulate. Always avoid harsh materials that can scratch or mar the instruments surface.
3. Rinse the instruments thoroughly with deionized water following the cleaning process.
4. After cleaning, inspect the instruments to ensure that all visible contamination has been removed. Repeat cleaning if any contamination is visible.
5. Dry the instruments using a clean, soft cloth.

Caution: Low acid or high alkaline solutions are not recommended as they corrode metal parts and anodized aluminum and compromise polymer plastics.

STERILIZATION

Do not stack sterilization case trays during sterilization.

Recommended parameters for steam sterilization for the Surgical Toolset in Agili-C Sterilization Case or in a FDA-cleared sterilization wrap:

Gravity Displacement Steam Cycle

Temperature 121°C (249.8 ˚F)

Full cycle time: 30 minutes

Drying time: 20 minutes

Pre-Vacuum

Temperature 132°C (269.6 ˚F)

Full cycle time: 4 minutes

Drying time: 20 minutes

Limitation on Reprocessing

Inspect the tools before use and do not use if visible signs of wear and damage are present.

The Agili-C Reusable Toolset has been tested for 40 reprocessing cycles.

CartiHeal

Agili-C Implantation: Surgical Technique

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Agili-C Implantation: Surgical Technique

- For complete Operative Technique see: *Agili-C Surgical Technique Quick Guide*
- For complete Indications, Contraindications, Warnings and Precautions see: *Agili-C IFU*

Agenda: Surgical Technique

1. Basic implantation
2. Proximal implants
3. Central trochlear lesion
4. Implantation close to the notch (uncontained lesion)
5. Revision – implant removal & replacement

1. Basic implantation

Agili-C™ - Surgical Toolset

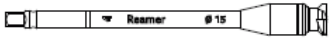
- **Perpendicular Aligner**

- **K-wire**

- **Drill Sleeve**

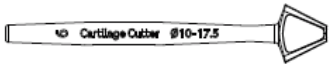
- **Drill Bit**

- **Reamer**



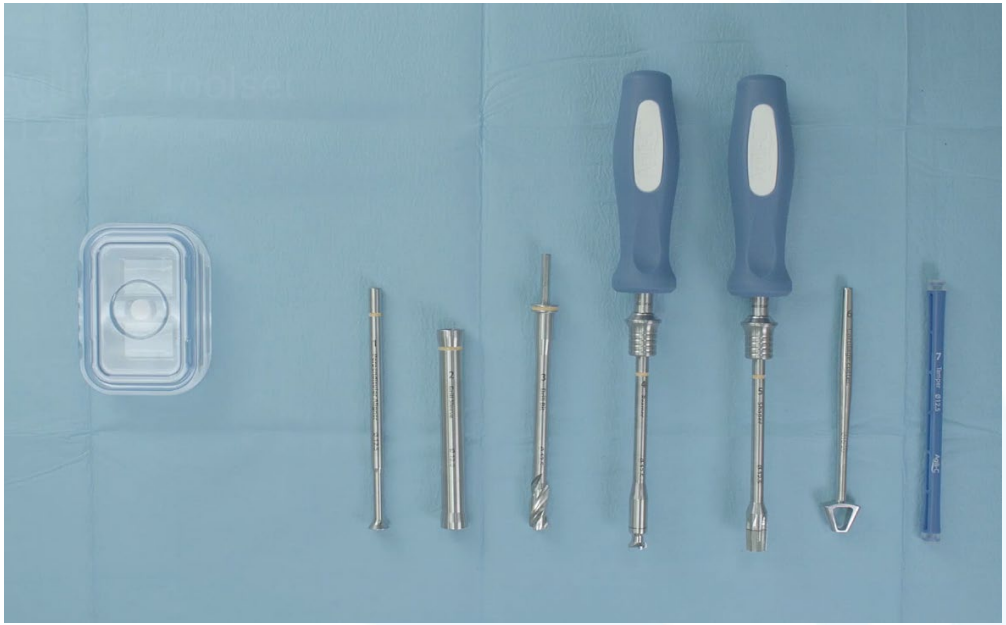
- **Shaper**

- **Cartilage Cutter**



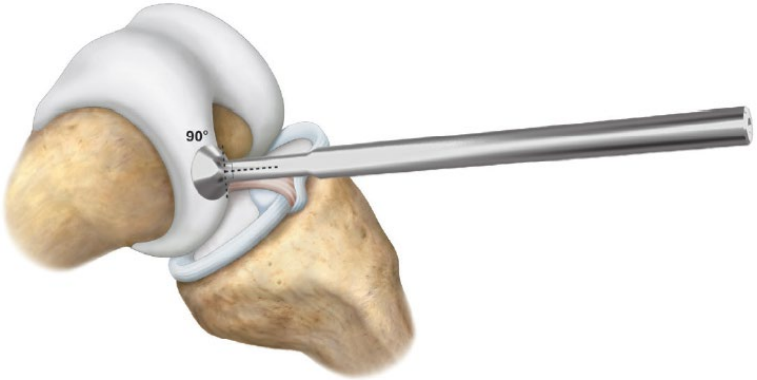
- **Quick-connect handle**

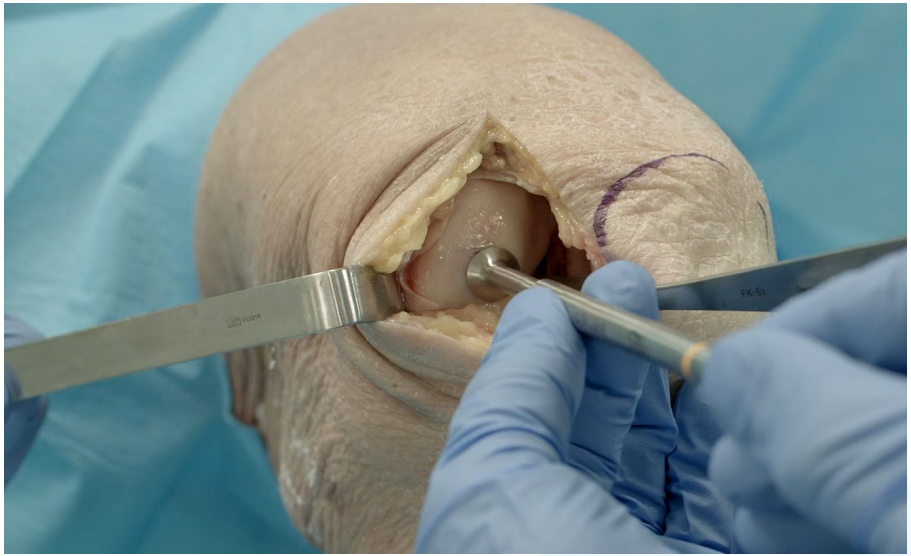
- **Tamper**



Step 1. Perpendicular Aligner Positioning

Position the **Perpendicular Aligner** in the lesion center and verify that it is perpendicular and in full contact with the articular surface in all 360˚



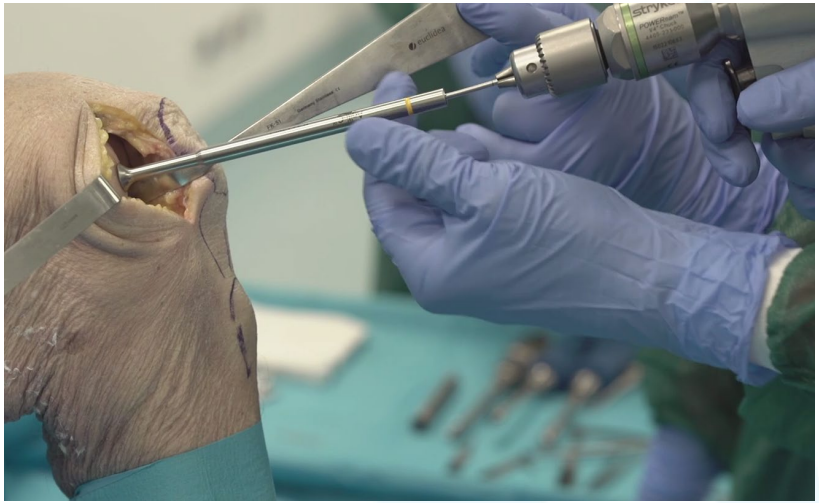


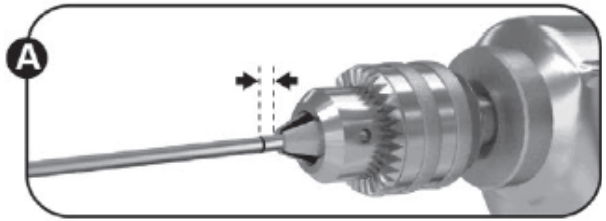
Step 2. K-Wire Drilling

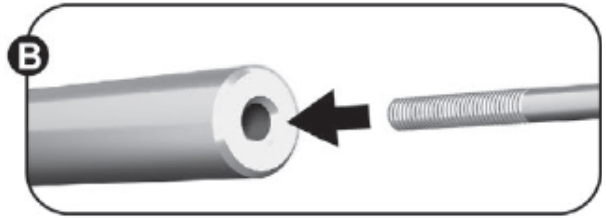
A. Place the **K-wire** in a motorized drill so that the indicator line is visible

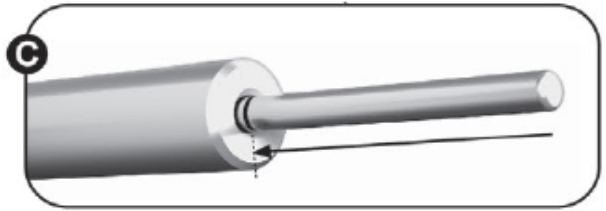
B. Thread the **K-wire** through the **Perpendicular Aligner** and drill it into the lesion until the indicator line reaches the proximal end of the **Perpendicular Aligner**

C. Release the **K-wire** from the motorized drill



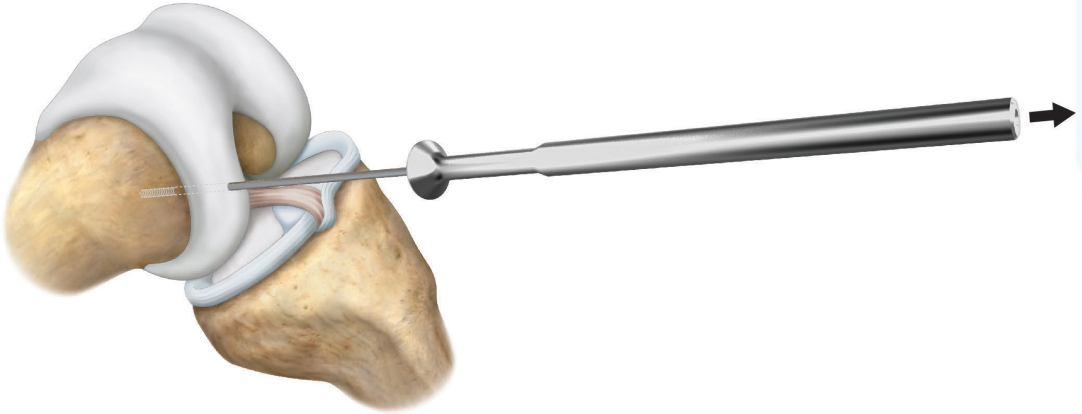






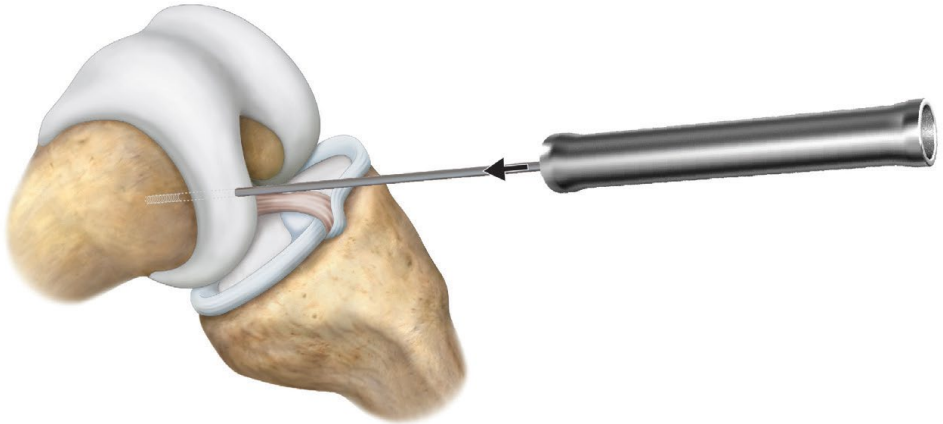
Step 3. Remove the Perpendicular Aligner

Remove the **Perpendicular Aligner.**
The **K-wire** remains in place



Step 4. Drill Sleeve Positioning

Place the **Drill Sleeve** over the K-wire

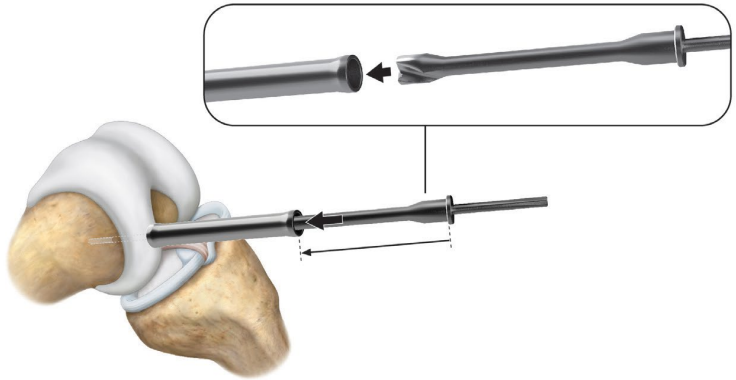


Step 5. Drill the Implantation Site

A. Place the **Drill Bit** into a motorized drill

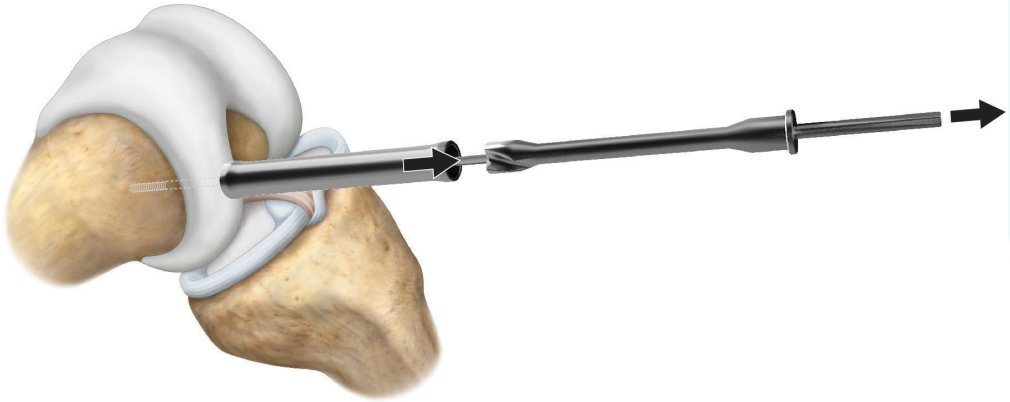
B. Hold the **Drill Sleeve** firmly against the articular surface

C. Thread the **Drill Bit** into the **Drill Sleeve** over the **K-wire** and drill until it reaches a stop



Step 6. Remove the Drill Bit and Drill Sleeve

Remove the **Drill Bit** and **Drill Sleeve.**
The **K-wire** remains in place

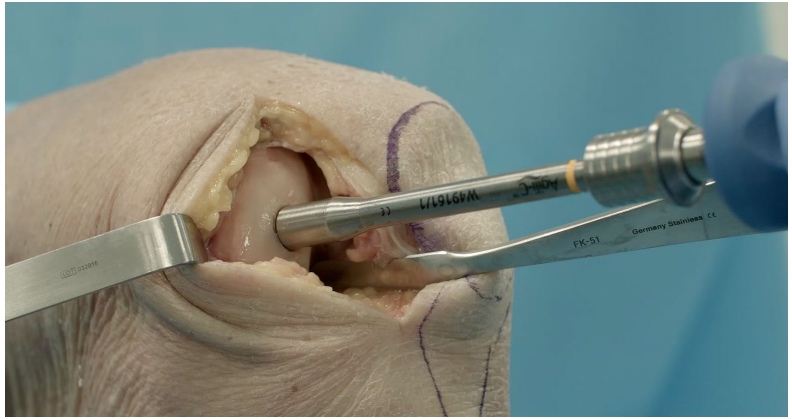


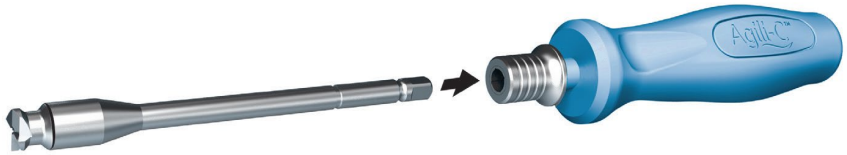
Step 7. Manual Deepening of Implantation Site

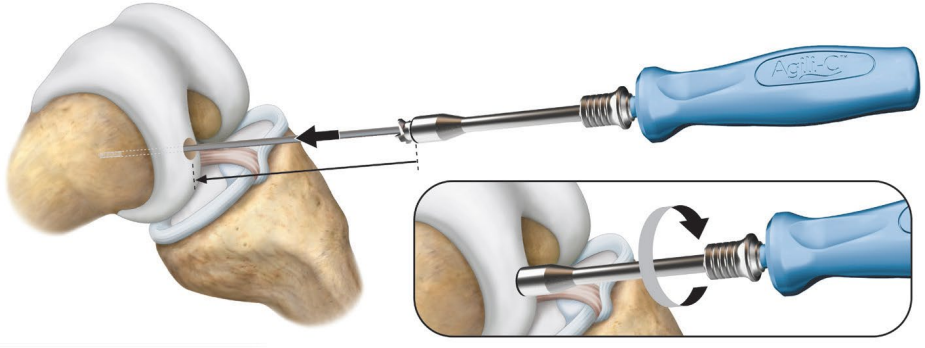
A. Connect the **Reamer** to the **Quick-connect Handle**

B. Insert the **Reamer** over the **K-wire**

C. Manually rotate the **Reamer** clockwise until the indicator line is no longer visible from all sides to ensure the correct depth of the hole

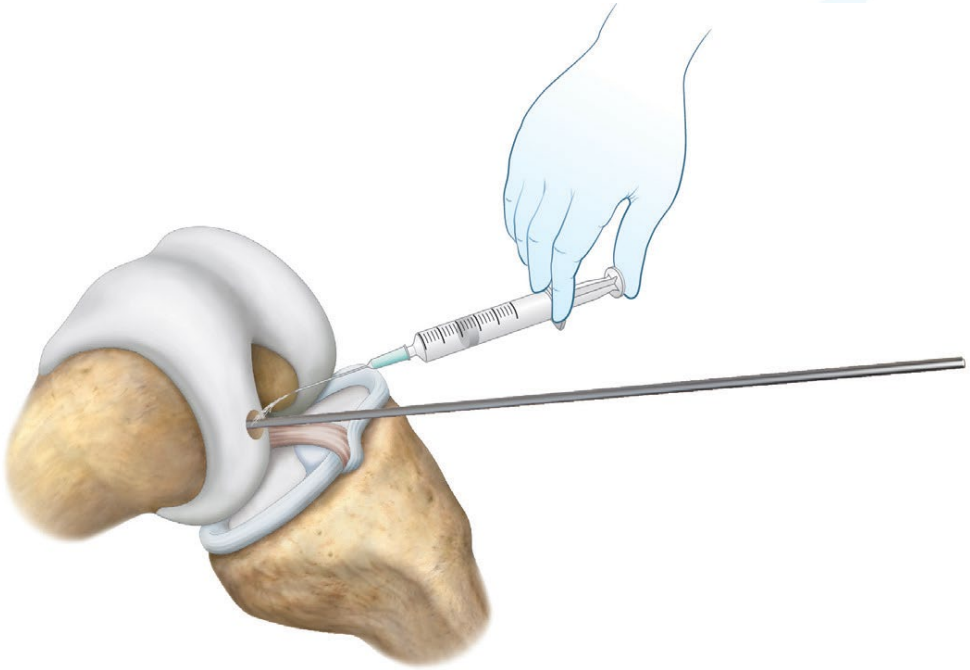






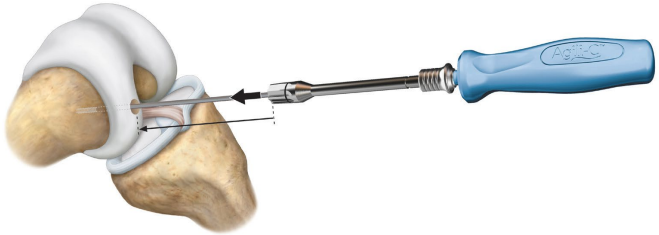
Step 8. Wash Implantation Site

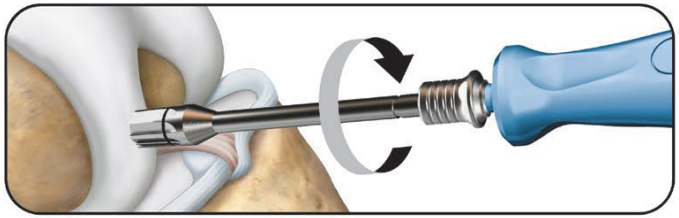
Remove the **Reamer** and rinse the hole with saline to wash out any debris.
The **K-wire** remains in place.

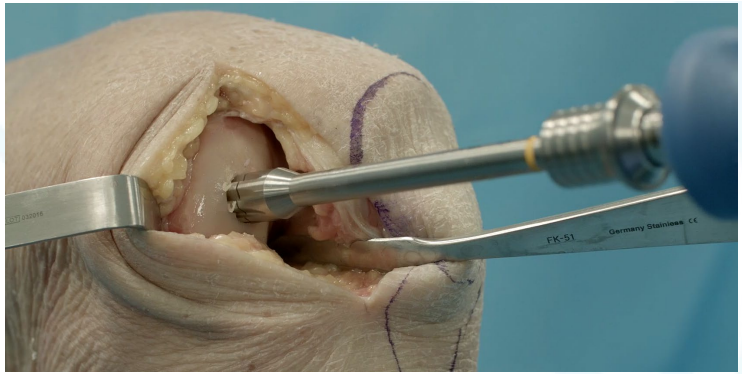


Step 9. Manual Shaping of Implantation Site

1. Release the Reamer from the Quick-connect handle and connect the **Shaper** to the **Quick-connect handle**
2. Insert the **Shaper** over the **K-wire**
3. Manually rotate clockwise until the indicator line is no longer visible from all sides and Shaper rotates smoothly



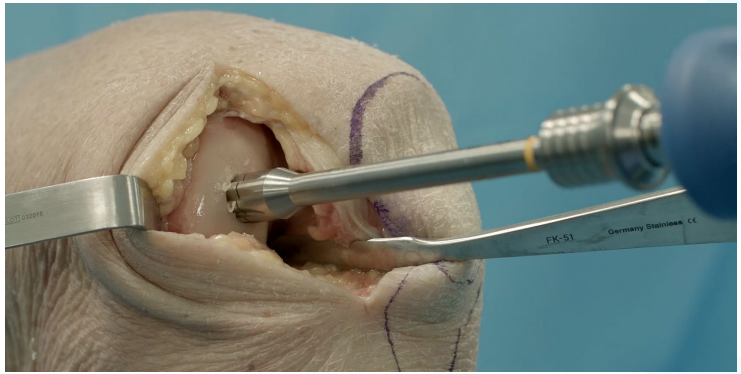




Step 9. Manual Shaping of Implantation Site

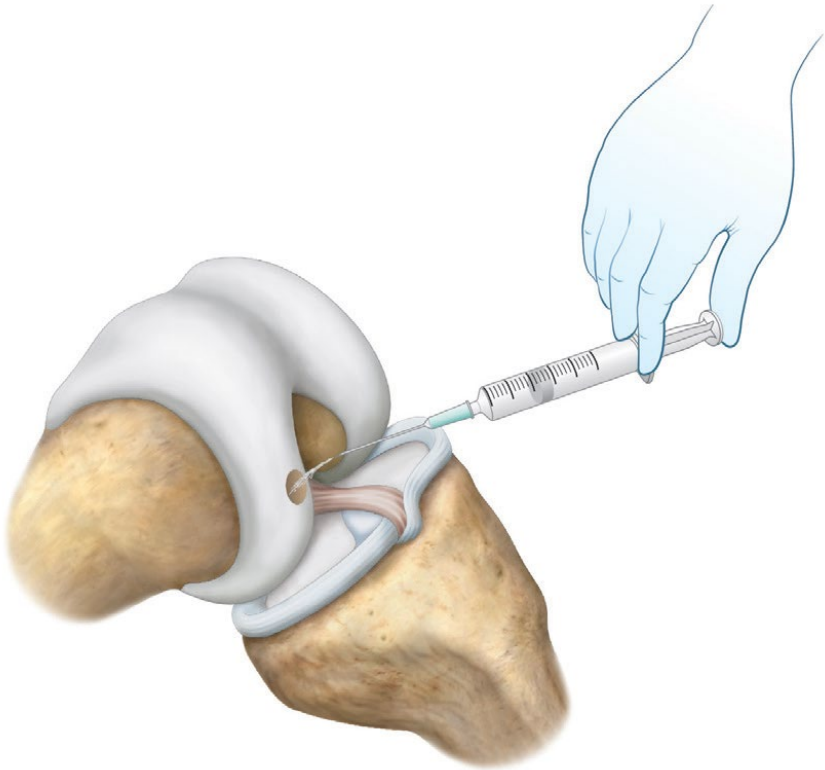
Repeat steps 7-9 at least 3 times until the Shaper is rotating smoothly in the hole.

Caution: Avoid wobbling While Rotating the Shaper



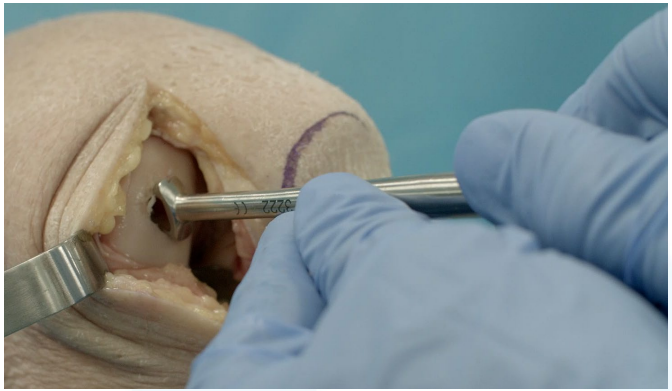
Step 10. Wash Implantation Site

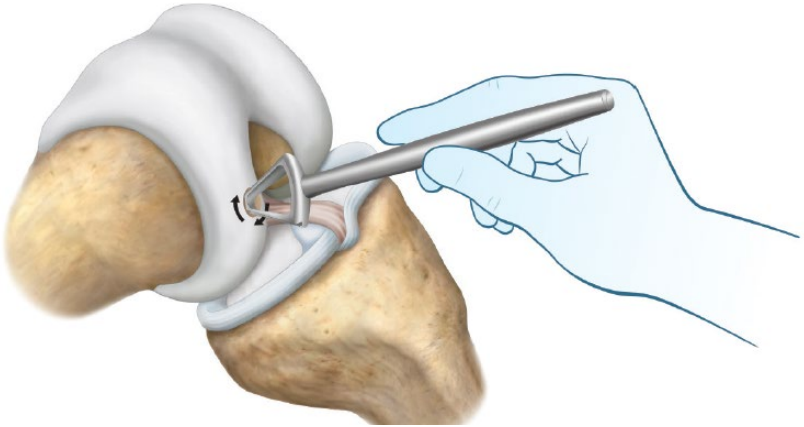
Remove the **Shaper** and the **K-wire** and rinse the hole with saline to wash out any debris



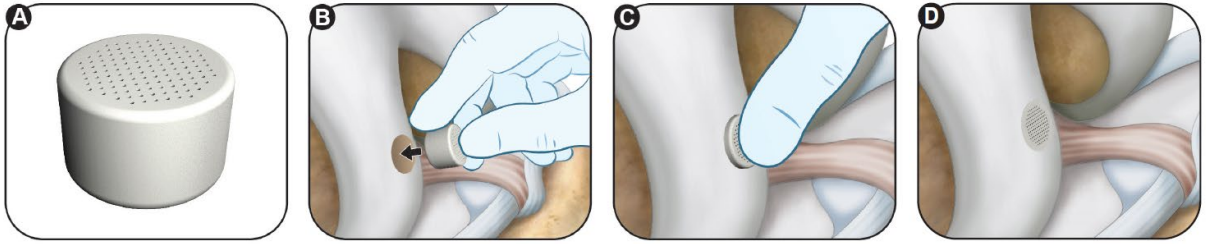
Step 11. Trimming Peripheral Cartilage

Trim the peripheral cartilage using the **Cartilage Cutter** or a scalpel to ensure smooth edges and to avoid invagination during implant insertion





Step 12. Agili-C™ Implant Inserting



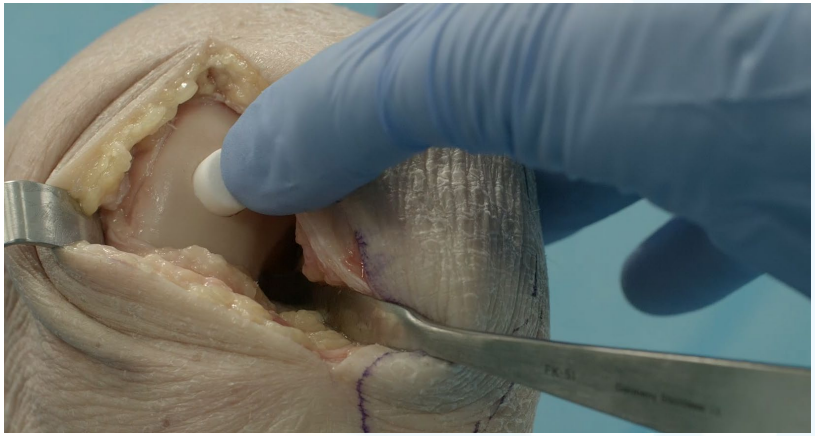
A. Agili-C™ implant

B. Manually insert the Agili-C™ implant into the hole

C. Firmly push the implant using the thumb until it is flush with the articular cartilage

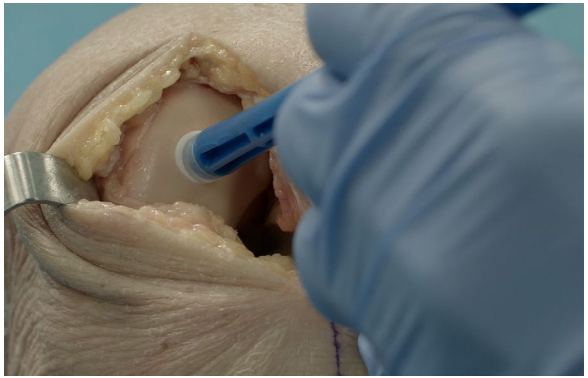
D. Implant flush with the articular cartilage

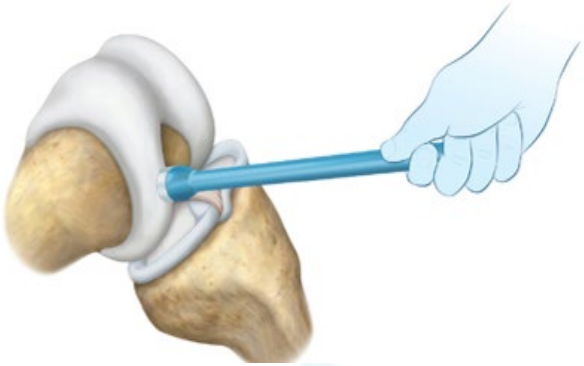
Change gloves prior to implant insertion



Step 13. Agili-C™ Final Positioning

Gently push the **Tamper** to insert the **Agili-C™ implant** so its final position is **2mm** below the surface of the articular cartilage



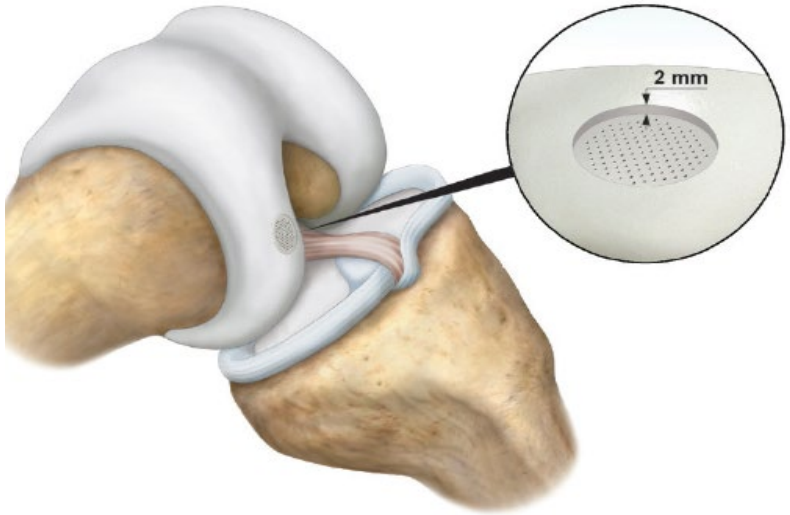


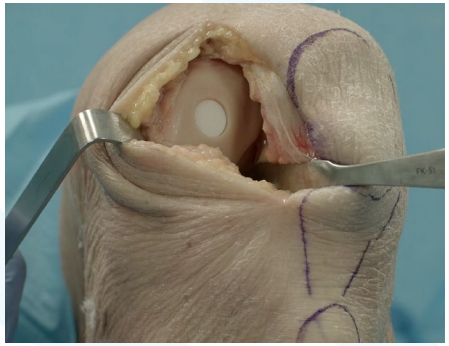
Caution : Do not use a hammer during the Agili-C™ implantation procedure!

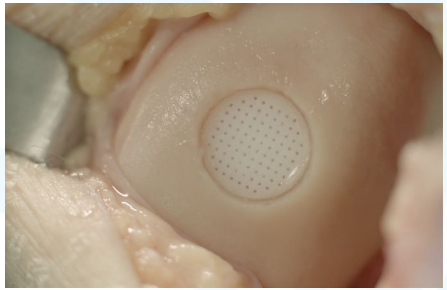
The Implant is brittle and can break if a hammer is used

Step 13. Agili-C™ Final Positioning

Gently push the **Tamper** to insert the **Agili-C™ implant** so its final position is **2mm** below the surface of the articular cartilage

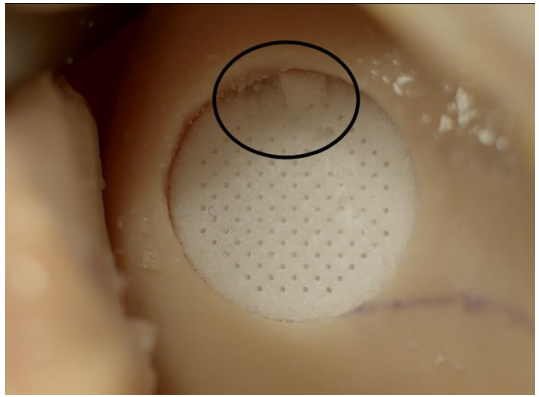


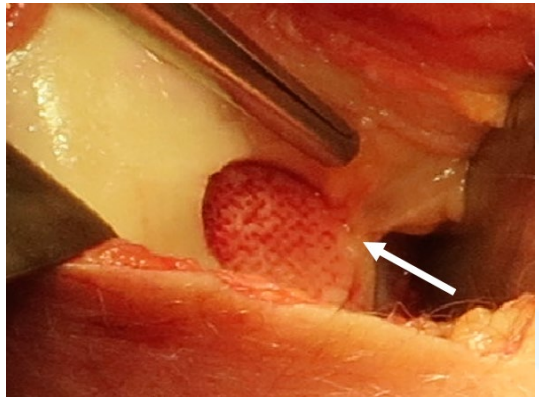




Surgical Technique Precautions

- During and post implantation visually inspect the **Agili-C™ implant** to make sure that it is not fractured. If the **Agili-C™ implant** was fractured during implantation, remove it and replace with a new implant
- The **Agili-C™ implant** must be recessed relative to the articular surface. Remove any protruding implants and replace with a new implant
- Verify there was no entrapment of soft tissue and no cartilage invagination
- In case of bone wall violation or an uncontained implantation site, do not use the Agili-C implant

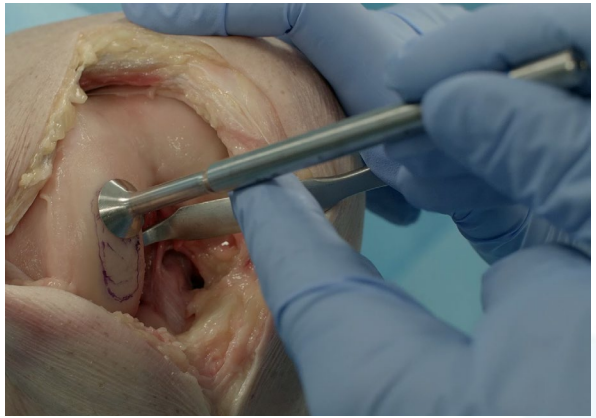


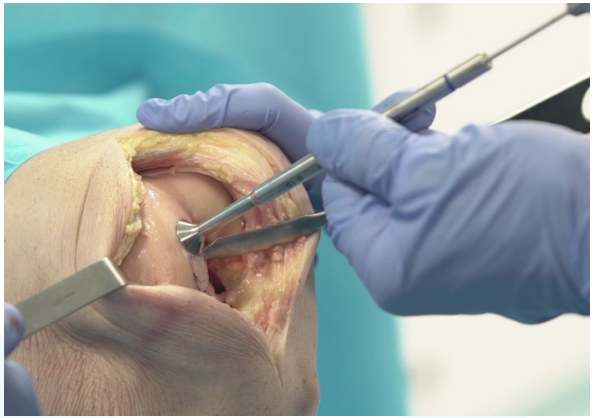


2. Implantation of Two Proximal Implants

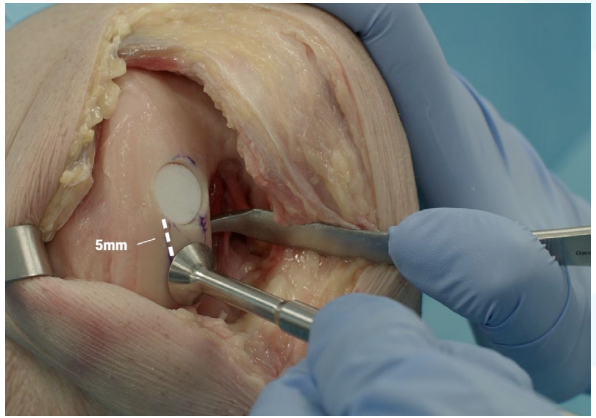
Two Proximal Implants

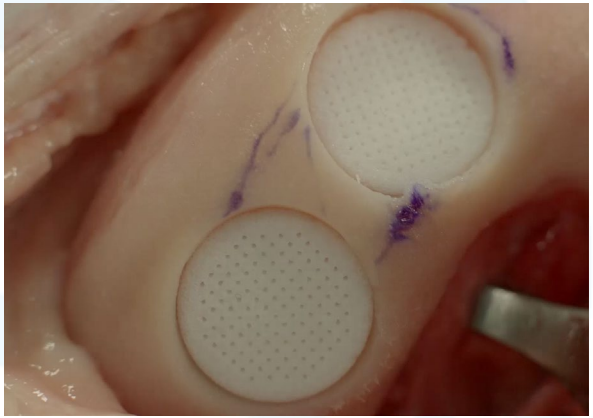
Step 1- position the first 1st implant close to any edge of the defect





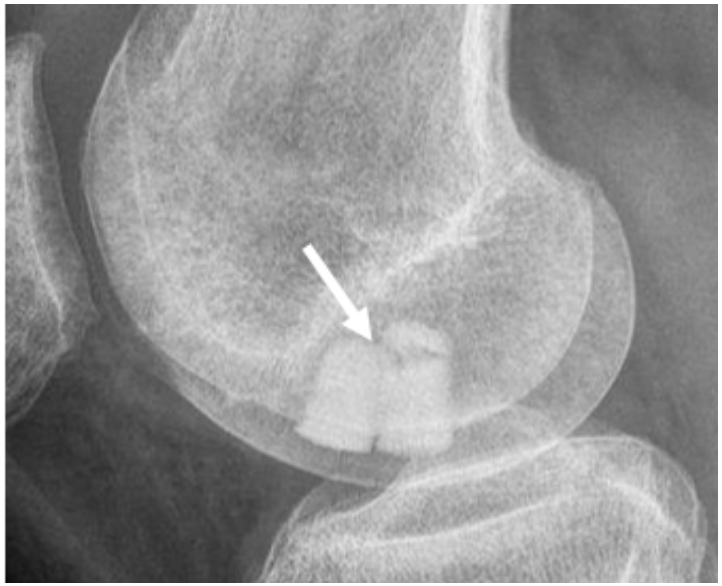
Step 2- position the 2nd implant on the other edge of defect with at least 5mm separation between implants

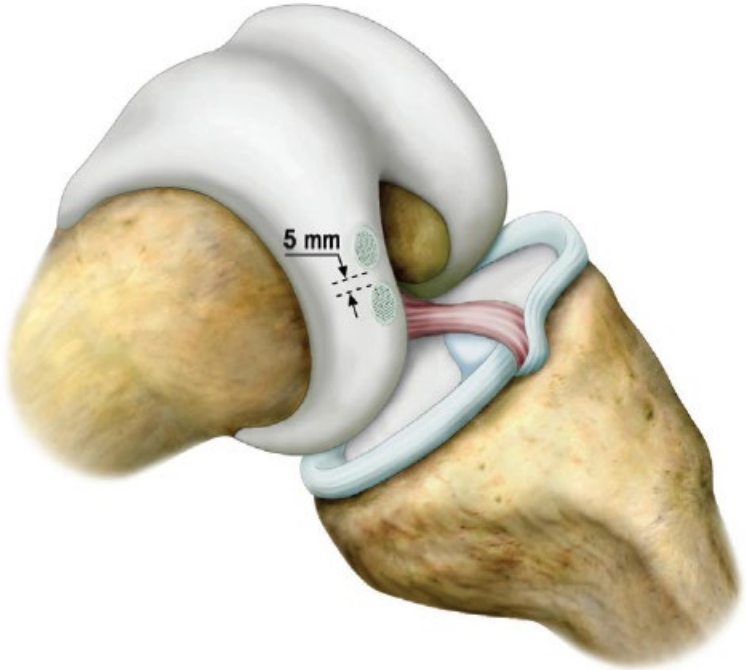




Two Proximal Implants

When multiple implants are used, it is important to keep a bone bridge of at least 5mm between implants to avoid **implant impingement at the bottom**





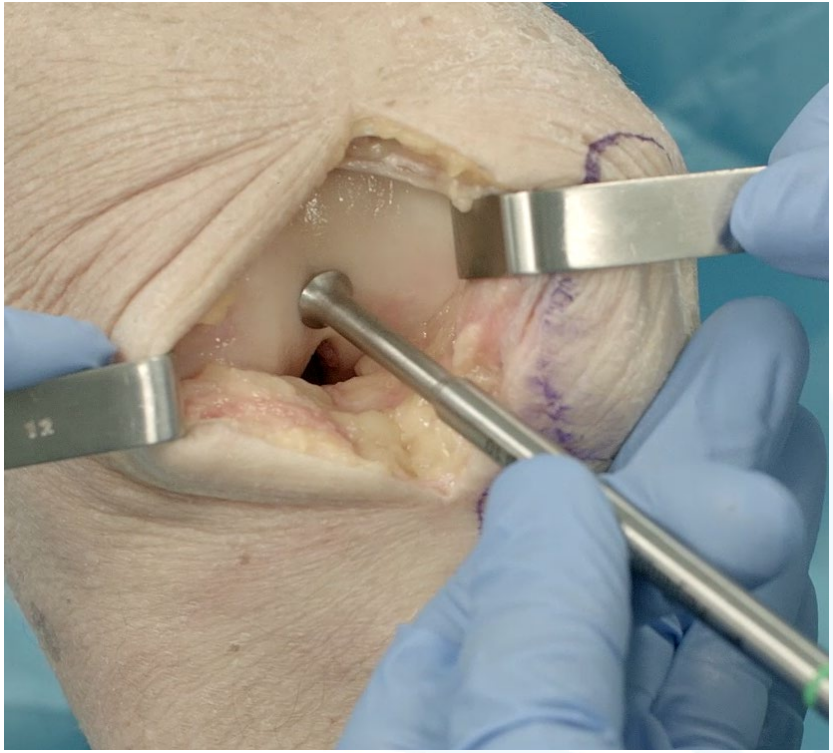
3. Implantation in a Central Trochlear Lesion

Central Trochlear Lesion

1. Position the **Perpendicular Aligner** in the center of the defect

2. Make sure the **Perpendicular Aligner** is stable on the medial and lateral Trochlear walls

3. Verify that it is perpendicular to the articular surface on anterior-posterior axis

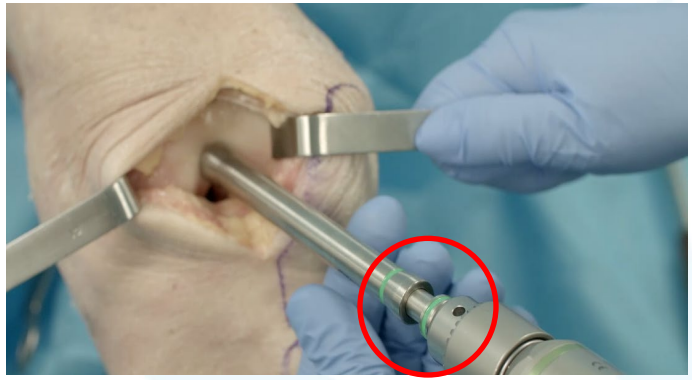


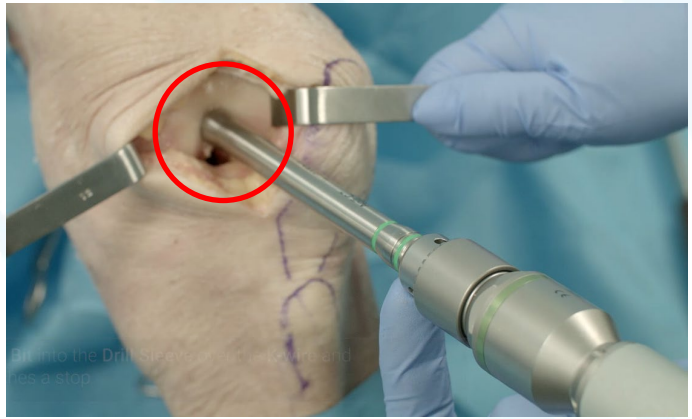
Central Trochlear Lesion

Hold the **Drill Sleeve** firmly against the articular surface

Thread the **Drill Bit** into the **Drill Sleeve** over the **K-wire** and drill until it reaches a stop

Due to the curved shape of the Trochlea, the **Drill Sleeve** will stop the **Drill bit** at a higher point (medial and lateral), preventing it from reaching the correct depth (anterior and posterior).

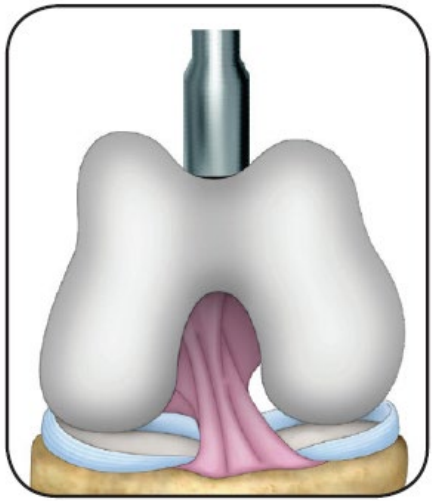


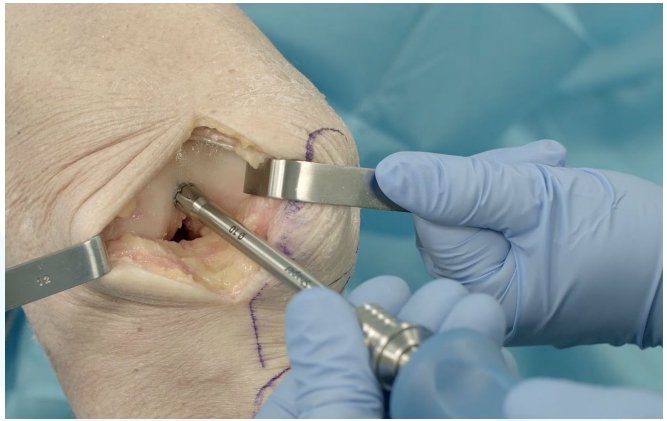


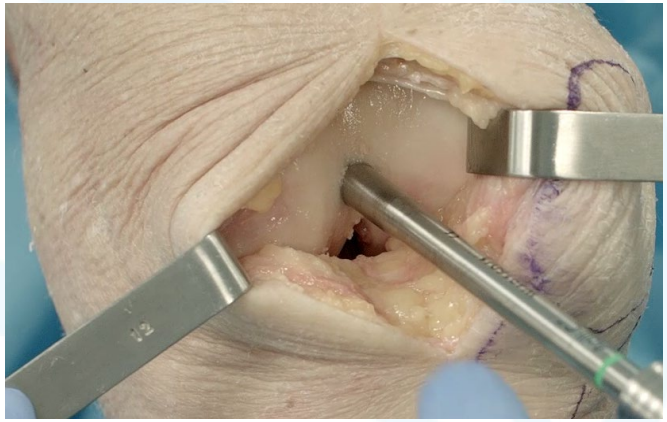
Central Trochlear Lesion

Manually rotate the **Reamer** and **Shaper** clockwise until the indicator line is no longer visible from all sides

The **Indicator line** should reach the articular surface on both posterior and anterior sides

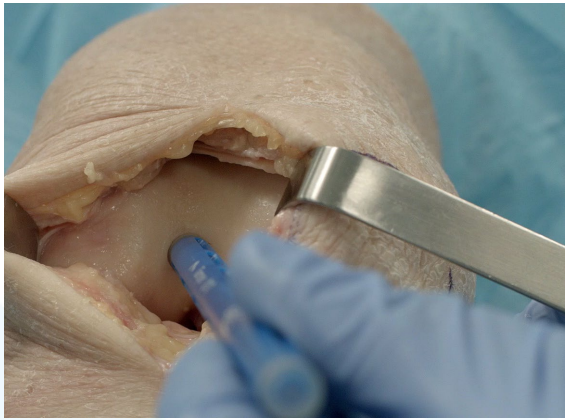






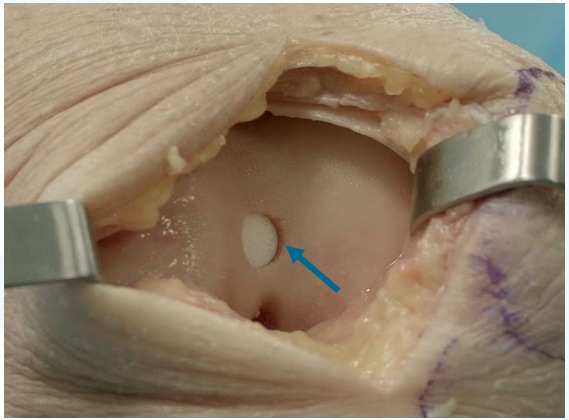
Central Trochlear Lesion

Gently push the **Tamper** to insert the Agili-C™ implant so its final position, is 2mm below the surface of the articular cartilage (at the highest point)



On the **anterior and posterior side** the implant should be leveled with the subchondral bone

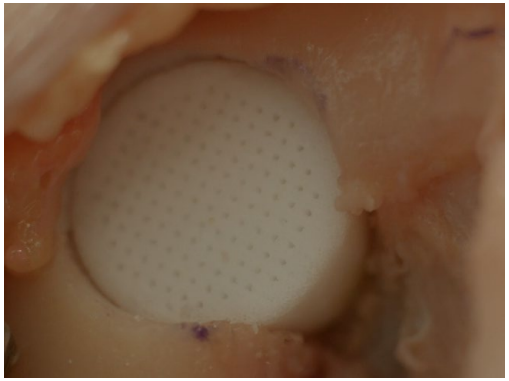
On the **lateral and medial side** the implant is expected to be below the level of the subchondral bone

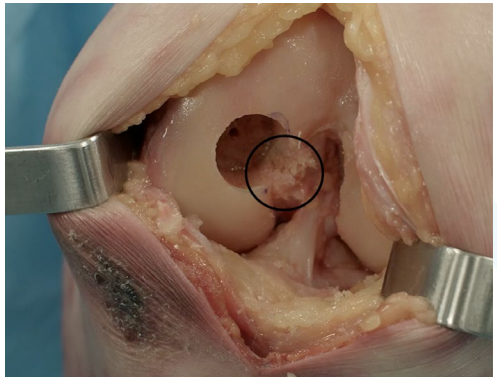


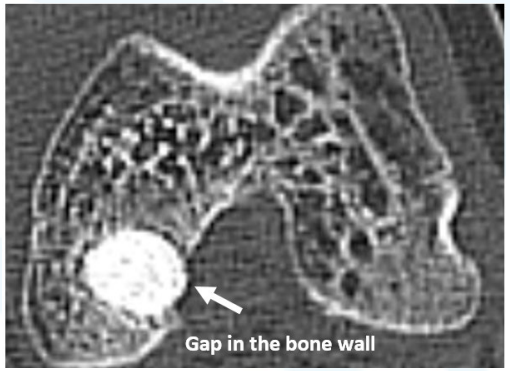
4. Implantation Close to the Notch – Uncontained Lesion

Implantation Close to the Notch – Uncontained Lesion

- The Agili-C implant must be completely surrounded by bone
- When Treating a lesion close to the intercondylar notch, it is crucial to make sure there is sufficient bone of at least 2mm around the lesion in order to avoid a bone wall violation
- **Caution: Bone wall violation (breakage at the notch side) and a protruding implant may cause implantation failure**







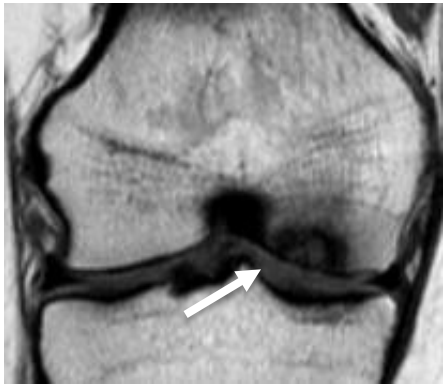
Example I: Incorrect Implantation, Female, 26yr

Causes of failure:

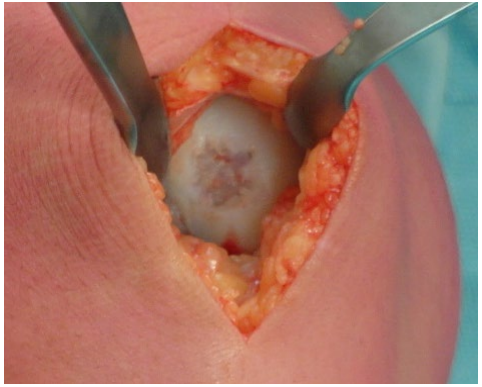
Bone wall violation (breakage at the notch side) and protruding implant

Revision: 6 months post procedure

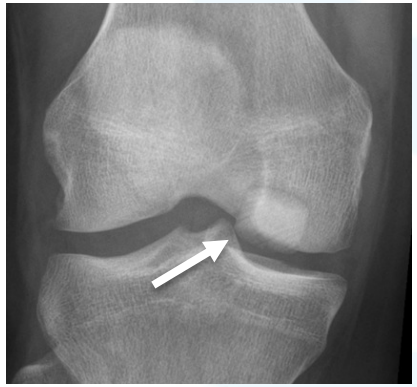
Pre-op MRI



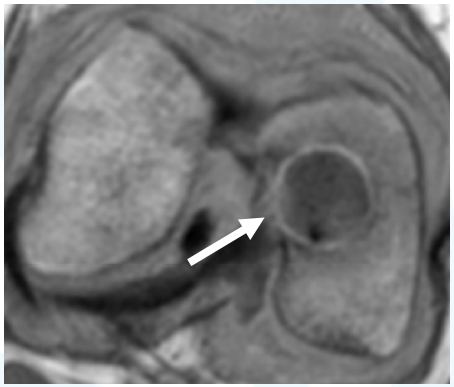
Lesion



X-ray 1 month post op



MRI 3 Months post op



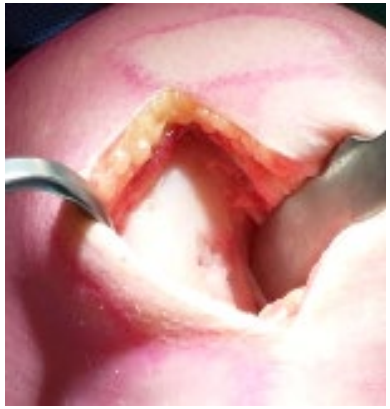
Example II: Incorrect Implantation, Female, 46yr

Cause of failure:

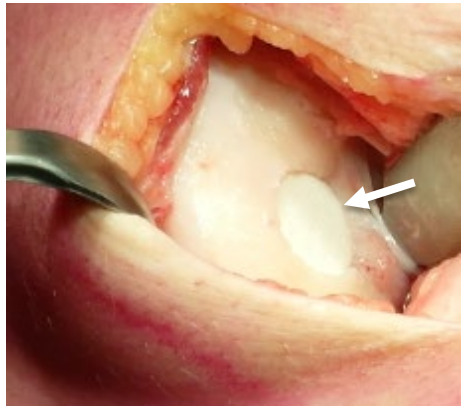
Implant is not fully surrounded by bone and protrudes into the notch

Revision: 10 months post procedure

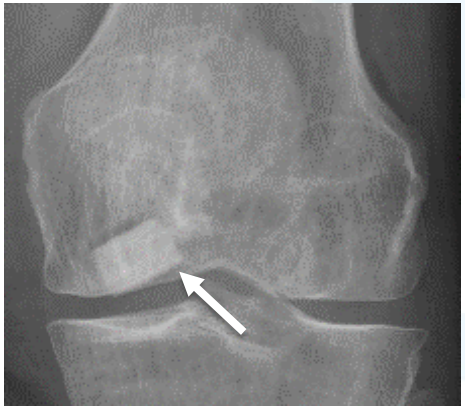
Notch OCD



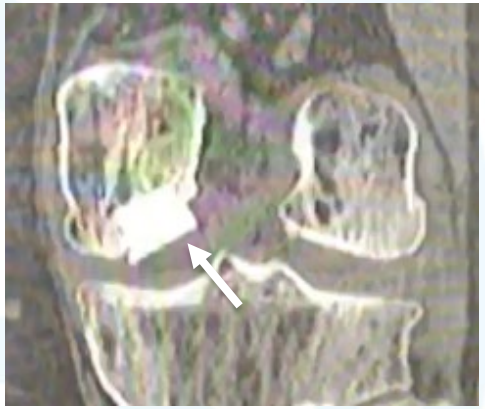
Implantation



Post op X –ray

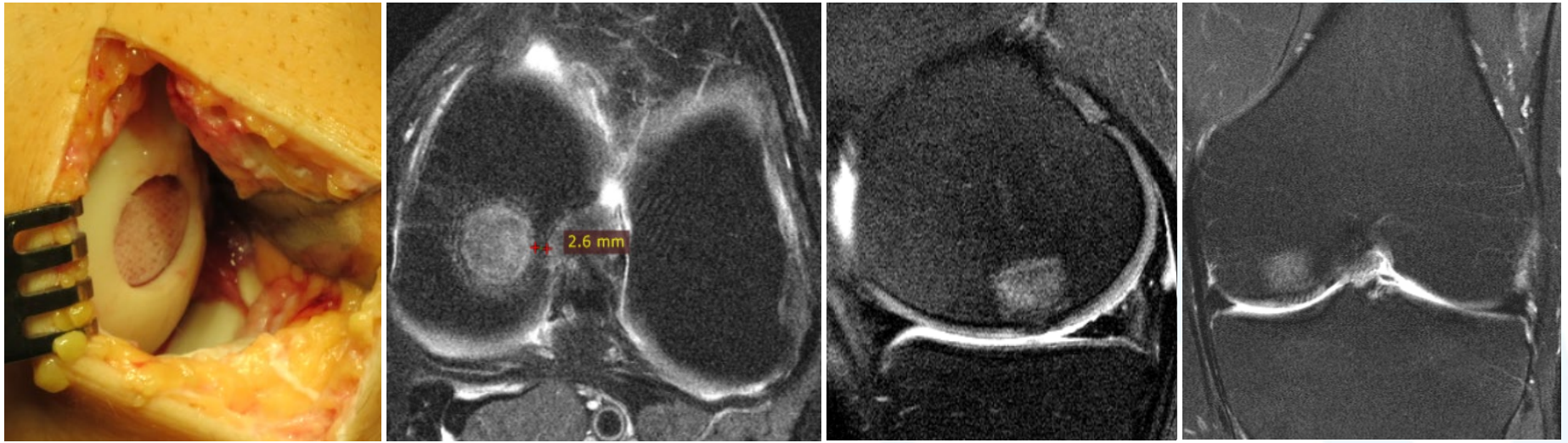


CT 4M post op



Example III: Correct Implantation, Male, 44yr

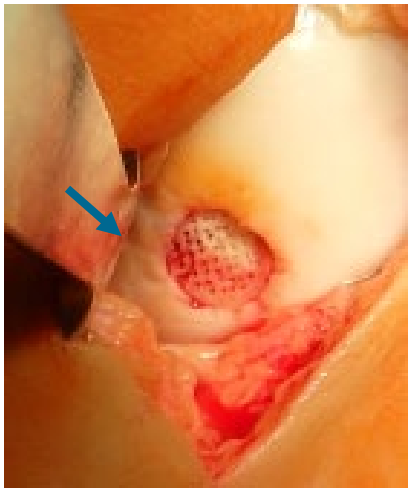
Implantation	MRI 18 month post op	MRI 24 month post op	MRI 36 month post op



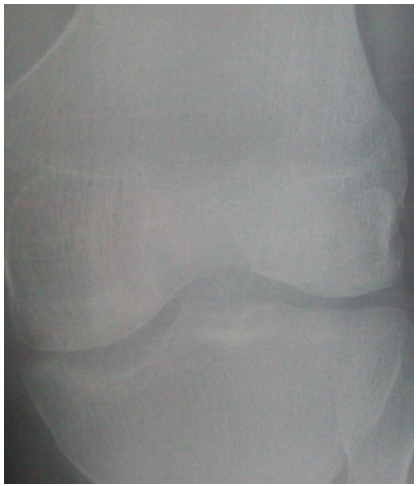
Bone wall was not violated & implant is not protruding

Example IV: Correct Implantation, Male, 20yr

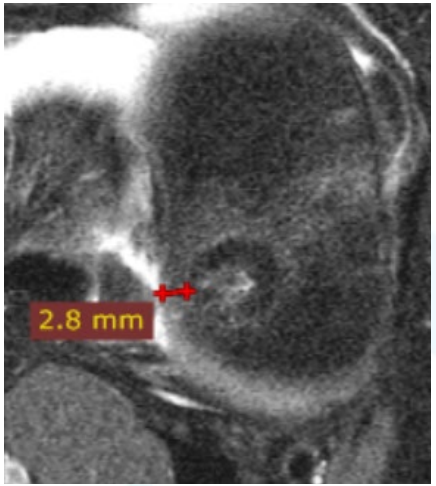
Implantation



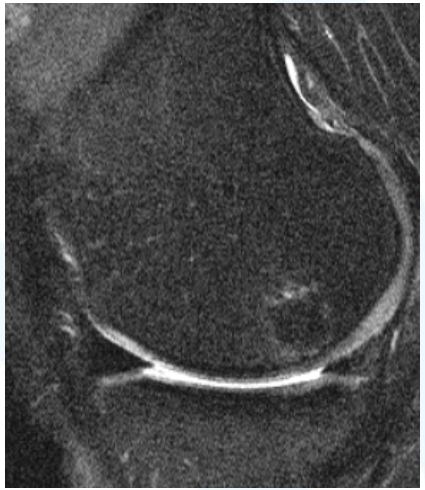
X-ray 12
month post op



MRI 12
month post op



MRI 24
month post op

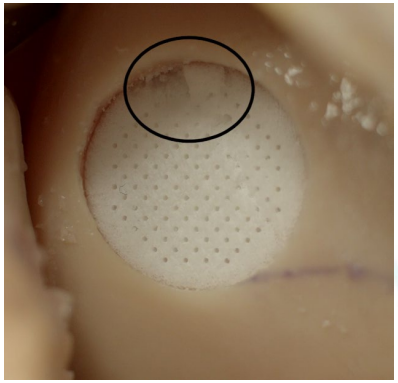


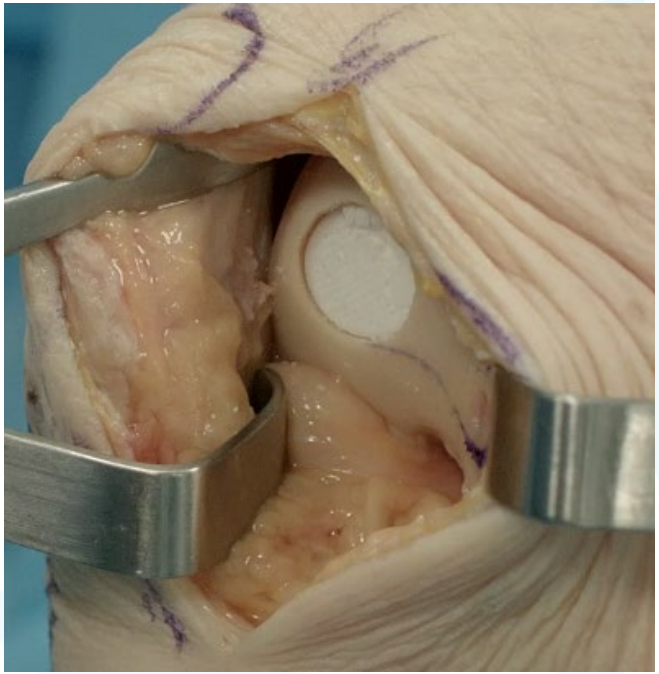
Bone wall was not violated & implant is not protruding

5. Revision –
Implant Removal & Replacement
(Due to Breakage / Protrusion)

Revision & Implant Removal

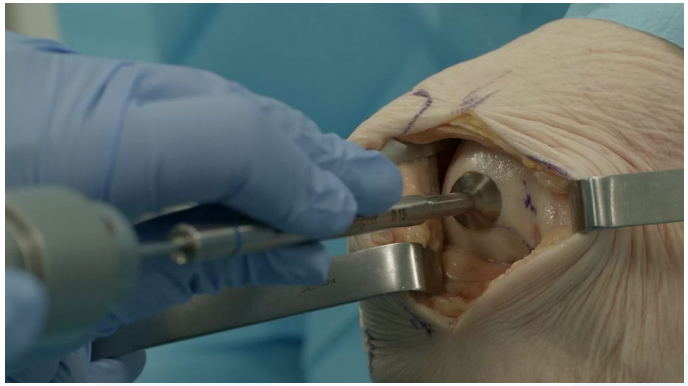
In the event an implant is fractured, or the implant is protruding - - remove the implant and use a new one

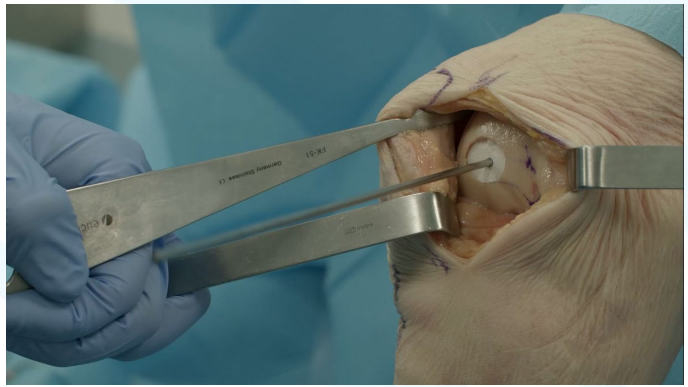




Revision, Implant Removal

1. Insert a **K-wire** to the center of the fractured implant, using the **Perpendicular Aligner** for centralization



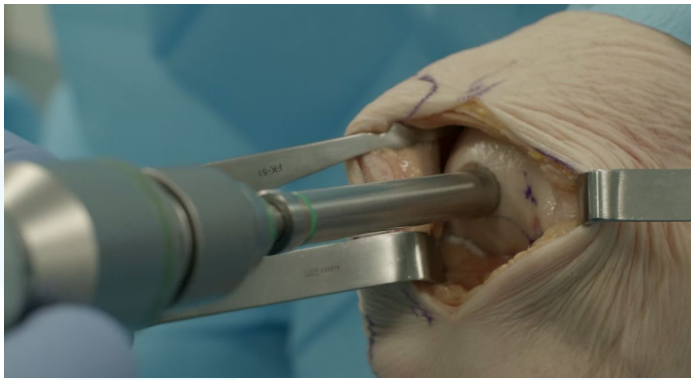


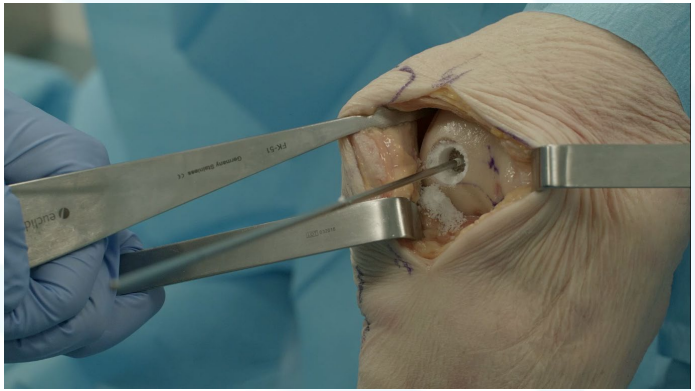
Revision, Implant Removal

2. Drill out the implant out using a smaller diameter **Drill Bit;** Do not forget to use the **Drill Sleeve**

Avoid contact with the bone wall

Wash thoroughly to remove all implant debris!



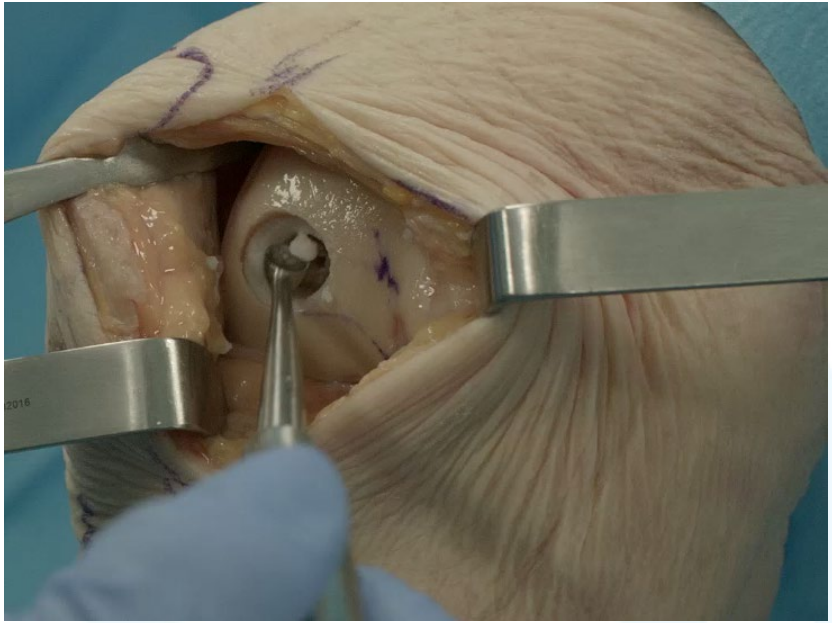


Revision, Implant Removal

3. Remove the remains of the implant manually

Make sure not to damage the bone wall and not to leave any debris

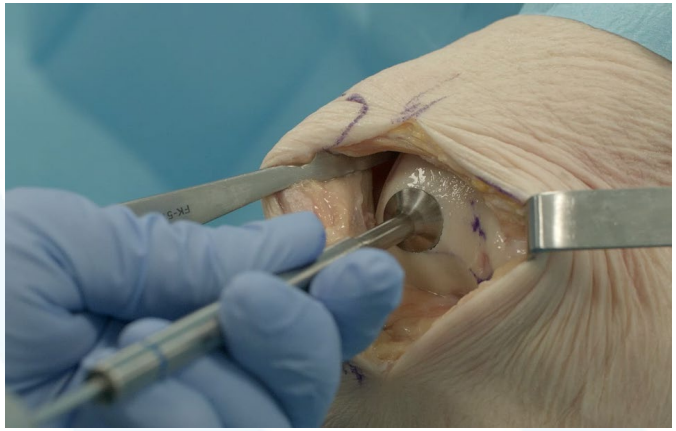
Wash thoroughly



Revision, Implant Removal

4. Hole preparation:

Thread the **K-wire** through the **Perpendicular Aligner** and insert it into the center of the implantation site (previously drilled)



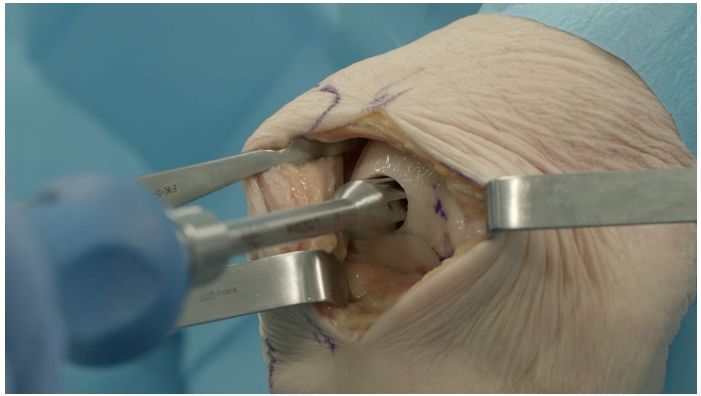
2 options when performing a revision:

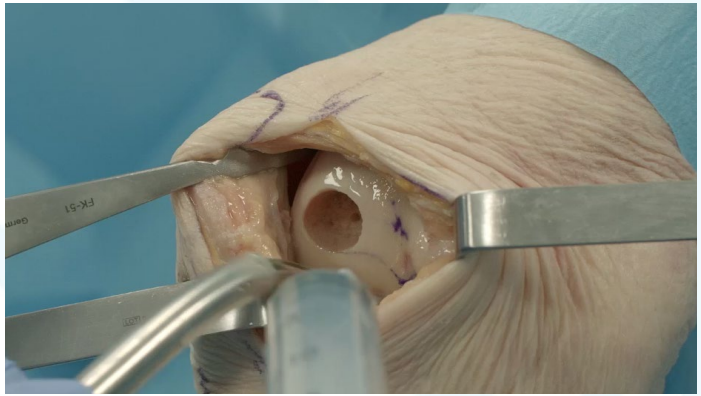
1. Use the **same implant diameter** as previously implanted – the drilled hole must be manually deepened with the **Reamer** by 1mm
2. Use a **larger implant**

Revision, Implant Removal

5. Manually rotate the **Reamer** and the **Shaper** clockwise until the indicator line has reached the articular surface on all sides

Wash thoroughly and change gloves prior to implant insertion





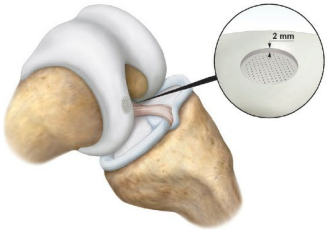
Revision, Implant Removal

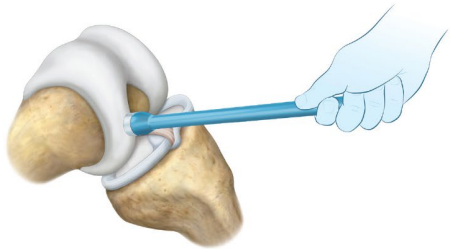
6. Implantation:

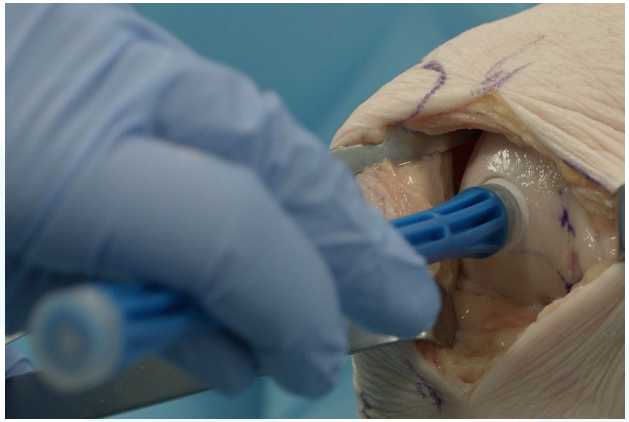
Manually insert the **Agili-C™** implant into the hole

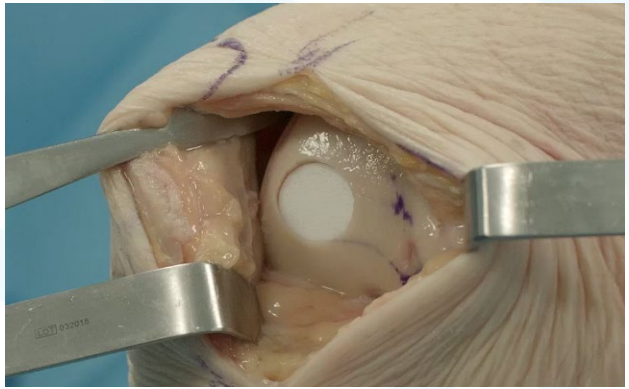
Firmly push the implant using the **thumb** until the implant is flush with the articular cartilage

Gently push using the **Tamper** to insert the **Agili-C™** implant so its final position is 2mm below the surface of the articular cartilage





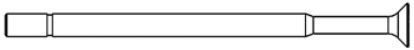
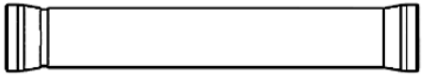
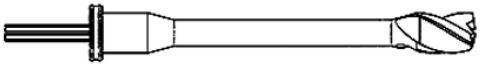
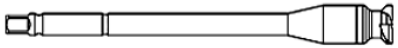




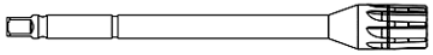
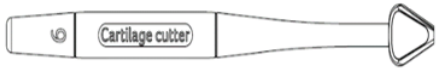
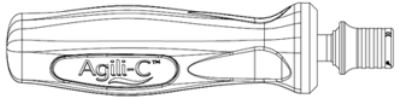
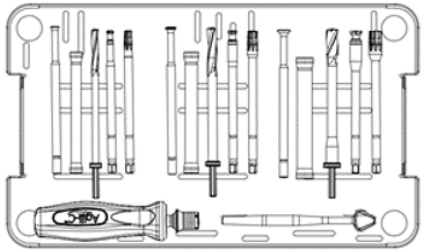
Ordering Information

Implant Diameter (mm)	**Implant Length** (mm)	**Catalog Number**
7.5	10	CMD-IP0040BUS
10	10	CMD-IP0088BUS
12.5	10	CMD-IP0912BUS
15	10	CMD-IP0530BUS

Ordering Information

Tool Name	Part Number
Perpendicular Aligner: 	D7.5: DPDS0329 D10: DPDS0330 D12.5: DPDS0331 D15: DPDS0332
Drill Sleeve: 	D7.5: DPDS0335 D10: DPDS0336 D12.5: DPDS0337 D15: DPDS0338
Drill Bit: 	D7.5: DPDS0341 D10: DPDS0342 D12.5: DPDS0343 D15: DPDS0344
Reamer: 	D7.5: DPDS0347 D10: DPDS0348 D12.5: DPDS0349 D15: DPDS0350

Ordering Information

Shaper: 	D7.5: DPDS0353 D10: DPDS0354 D12.5: DPDS0355 D15: DPDS0356
Cartilage Cutter 	D7.5 - D10: DADS0234 D7.5 - D12.5: DADS0003 D12.5- D20: DADS0267
Quick Connect Handle 	DPDS0359 DPDS0360
Sterilization case: 	DPDS0893

Ordering Information

Reusable Toolset Size	Catalog Number
Ø7.5L10	TS00075U
Ø10L10	TS00100U
Ø12.5L10	TS00125U
Ø15L10	TS00150U

Agili-C MTD Size	Catalog Number
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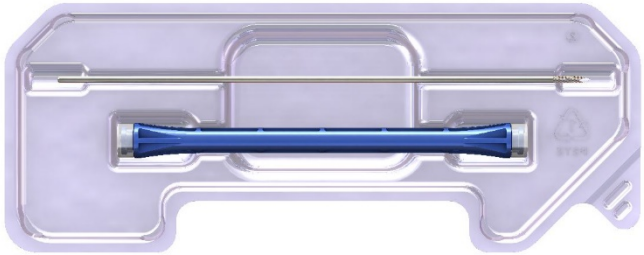
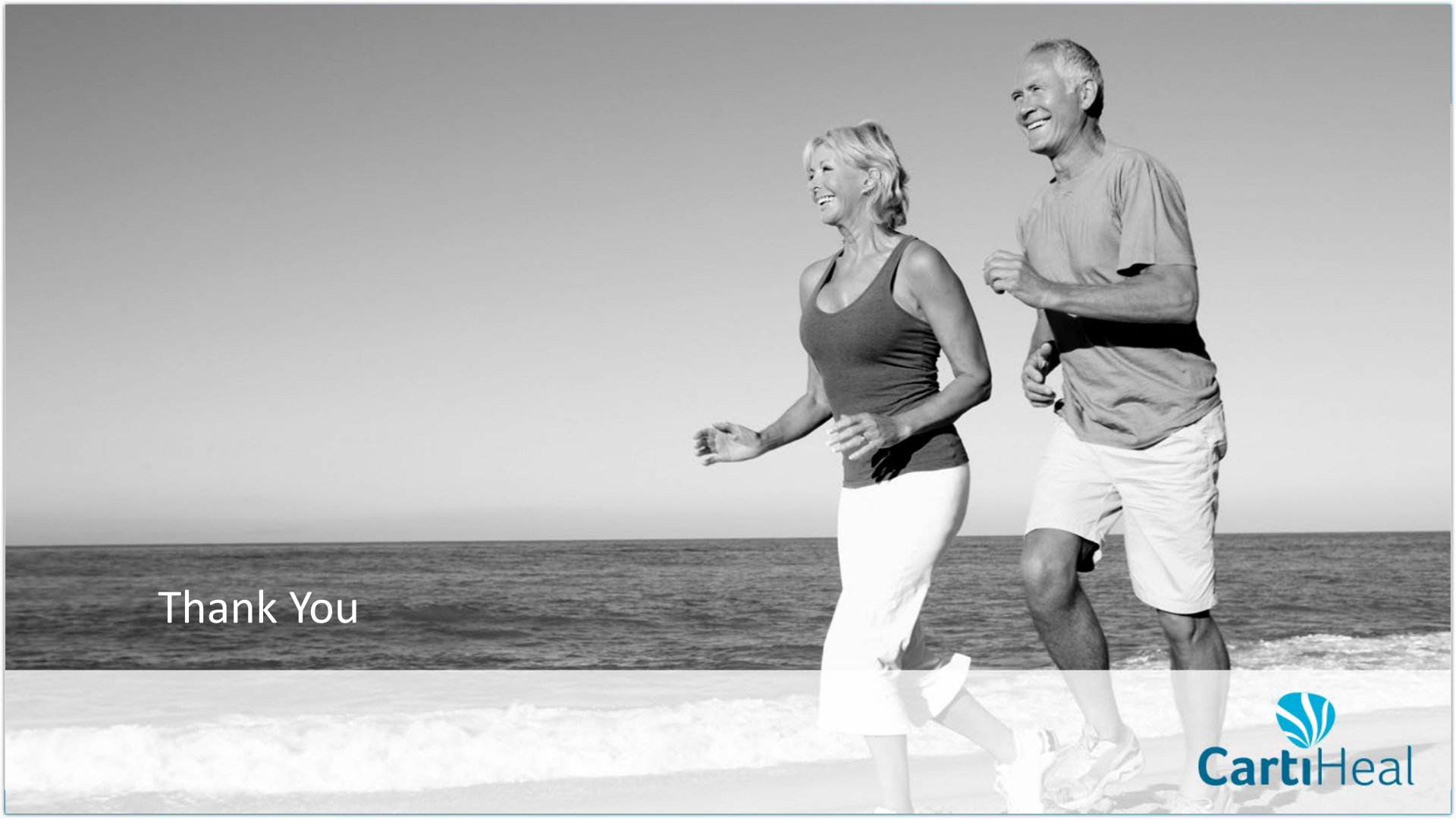
Ø10	159-22281-02
Ø12.5	159-22281-03
Ø15	159-22281-04



Information

- For complete Operative Technique and Instructions for Us see:
  QAD0060 Agili-C Surgical Technique Quick Guide (US)
  QAD0066 Agili-C IFU (US)

CartiHeal
Atir Yeda 17, Kfar Saba, 4464313
Israel
Tel: +972 9 8810400 Fax: +972 9 8810401
info@cartiheal.com
www.cartiheal.com


Thank You
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