For the treatment of spinal stenosis, surgeons have various treatment options. The continuum of care includes conservative care, interspinous distraction, direct decompression with or without additional stabilization and finally fusion.

The surgical treatment options all have in common, that the decompression of the stenotic segment addresses mainly the leg symptoms, whereas back pain often remains residual.

Kleinstück et al.¹ have analyzed the impact of the degree of back pain in relation to the leg pain on the outcomes for spinal stenosis patients after decompression.

They discovered a significant correlation between the degree of associated back pain and outcome. Patients who presented themselves with significant back pain in addition to their leg pain had a significantly worse outcome after decompression.

The clinical outcome after decompression treating lumbar spinal stenosis depends significantly on the degree of associated back pain.

¹ Kleinstück et al. The Influence of Preoperative Back Pain on the Outcome of Lumbar Decompression Surgery. Spine 2009; Volume 34; Number 11; pp 1198-1203

2 FDA: Food and Drug Administration

SPINAL STENOSIS WITH BACK PAIN – THE RATIONALE FOR STABILIZATION

The authors of the study state in their discussion that “future studies should also assess whether the addition of fusion to decompression in patients with notable LBP (low back pain) results in a better overall outcome.”

The coflex®-FDA² study addressed just that. Patients in the study had to have significant back pain in addition to their leg pain. After microsurgical decompression, the operated segment was stabilized; either through the coflex® implant or, through pedicle screw fusion.

Patient satisfaction of more than 90% in the coflex® group and more than 80% in the fusion group for this challenging patient population clearly shows:

Back pain in patients with spinal stenosis can be effectively addressed through additional stabilization!
Adjacent Segment – The Rationale for coflex®

In cases of spinal stenosis treatment requiring supplemental stabilization post decompression, fusion has been the only option for many years – an overtreatment in many cases? Extended operative time, a more complex OR setup and a greater need for intraoperative imaging can be a strain for surgeons, OR staff and patients. Adjacent segment breakdown may even require additional surgeries at a later stage.

The motion preserving coflex® procedure allows for a direct microsurgical decompression, Interlaminar Stabilization™ and foraminal height maintenance.

This technology also allows for facet off-loading and physiologic range of motion and translation at the index level, thereby maintaining physiological adjacent segment kinematics and restoring natural anatomic function.

The coflex® study demonstrated that on average, fusion patients exhibited more hypermobility at the adjacent segment at two years compared to coflex® patients.

Additionally, there was a statistically significant higher rate of adjacent segment surgery at two years in the fusion group, compared to the coflex® group.

The coflex® procedure is simple and elegant, while providing all the stability needed for pain relief.

Operative time, surgical intensity and overall patient morbidity is significantly reduced.

The coflex® procedure – Motion Preserving Interlaminar Stabilization™.
... WITH COMPARATIVE EFFECTIVENESS ...

coflex® – 1st Comparative Effectiveness Study in Stenosis!
All FDA studies are not the same – especially with 96% follow-up at 2 years. The coflex® study was designed as a prospective, randomized trial, which included independence of every activity (e.g. contract research organizations, data safety monitoring board, clinical events committee, biostatistician and core laboratory for radiographic analyses) in order to eliminate bias. More than 55,000 pages of patient CRFs, 12,000 radiographs and greater than 375,000 data points of Level 1 data were collected showing the coflex® benefits.

coflex® – A True Alternative to Fusion
The coflex® device outperformed fusion in nearly all clinical, radiographic, perioperative and health economic outcomes, measured through 589 data points evaluated for each individual study subject over a 2 year follow-up period. It has also demonstrated a lower overall surgical reoperation rate up to 4 years, as well as a lower rate of adjacent segment surgery at 2 years, compared to fusion.

coflex® – Saves Everyone Money
The use of coflex® leads to a decrease in operative time, hospital length of stay and patients’ blood loss. The coflex® procedure also provides an opportunity for a faster recovery and less narcotics to manage pain. It also controls costs, mitigates patient risk, delivers better patient outcomes and results in higher patient satisfaction compared to pedicle screw fusion.

coflex® – Intended Clinical Effect at Day 0
The intended clinical effect for coflex®, including direct surgical decompression, maintenance of foraminal height, and motion preservation, occurs at day zero compared to the unknown long-term effects of both failed and successful fusion after decompression.

1st ever prospective, randomized, controlled Level 1 study collecting comparative effectiveness data in spinal stenosis.
The coflex®-FDA study has demonstrated that the coflex® procedure benefits both your patients and your practice by focusing on:

**Your Time™**
- On average, the surgery with coflex® is an hour shorter than fusion surgery
- coflex® patients were able to return home two days earlier compared to fusion patients
- coflex® decreases the number of hospital rounds and follow-up visits
- coflex® reduces stress on your surgical care team
- coflex® offers the potential for outpatient surgery

**Your Patient Success**
- coflex® patients were more satisfied with their outcomes compared to fusion patients
- More coflex® patients would recommend the same treatment compared to fusion patients
- coflex® preserves motion and maintains physiological kinematics in the adjacent segments

**Your Efficiency**
- Decreased cost per procedure
- Only a few surgical steps
- Very few instruments
- Neuro-monitoring unnecessary
- Significantly reduced intraoperative fluoroscopy
- No concern of non-union

The coflex® procedure – for a greater peace of mind for everyone involved.

… FOR A GREATER PEACE OF MIND.
DESIGN RATIONALE

Over 15 years of clinical experience and almost 100,000 implantations worldwide have proven the clinical success of the coflex® implant. This device is ideal for spinal stabilization after surgically addressing neural compression from soft and bony stenosis of the spinal canal.

Intelligent Implant Design
- Excellent fatigue strength and durability
- Single-piece design; no wear debris
- Easy 1 and 2-level implantation

Functionally Loading and Motion Preserving
- Compressible in extension, allowing flexion
- Increased rotational stability
- Center of rotation close to spinal canal
- Load-sharing design

Simplicity
- 5 anatomical sizes
- Color coded instrumentation
- Titanium alloy; biocompatible; X-Ray visible
- Crimping of wings for increased primary stability
- Less invasive, tissue-sparing procedure
- Easy and precise application

2 PART FUNCTIONAL DESIGN

Interlaminar Stabilization™
- Unique coflex® design allows for deep insertion post surgical decompression
- Apex of “U” permanently maintains foraminal height
- Offloads facets and posterior annulus

Motion Preservation
- coflex® is compressible in extension
- Axial force shock absorption
- Maintains sagittal balance and lordosis
- Maintains physiological adjacent segment kinematics
**INDICATION**

The coflex® Interlaminar Technology is an Interlaminar Stabilization™ device indicated for use in one or two level lumbar stenosis from L1–L5 in skeletally mature patients with at least moderate impairment in function, who experience relief in flexion from their symptoms of leg/buttocks/groin pain, with or without back pain, and who have undergone at least 6 months of non-operative treatment. The coflex® is intended to be implanted midline between adjacent lamina of 1 or 2 contiguous lumbar motion segments. Interlaminar Stabilization™ is performed after decompression of stenosis at the affected level(s).

### Patient Profile

<table>
<thead>
<tr>
<th>Leg Pain</th>
<th>Back Pain</th>
<th>Instability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Intermittent neurogenic claudication</td>
<td>• Intermittent neurogenic claudication</td>
<td>• At least moderate stenosis</td>
</tr>
<tr>
<td>• Insignificant back pain</td>
<td>• Insignificant back pain</td>
<td>• At least moderate stenosis</td>
</tr>
<tr>
<td>• Early or infrequent symptomatology</td>
<td>• Too sick for general anesthesia</td>
<td>• Severe stenosis</td>
</tr>
<tr>
<td>• At least moderate stenosis</td>
<td>• Significant back pain (&gt; leg pain)</td>
<td>• Dominant back pain</td>
</tr>
<tr>
<td>• Intermittent neurogenic claudication</td>
<td>• Significant back pain (&gt; leg pain)</td>
<td>• Unstable spondylolisthesis &gt; Grade I</td>
</tr>
<tr>
<td>• Insignificant back pain</td>
<td>• No instability</td>
<td>• Unstable spondylolisthesis &gt; 25° Cobb Angle</td>
</tr>
<tr>
<td>• Early or infrequent symptomatology</td>
<td>• Stable spondylolisthesis up to 15%</td>
<td>• Degenerative lumbar scoliosis &gt; 25° Cobb Angle</td>
</tr>
<tr>
<td>• modification of daily activities</td>
<td>• Degenerative lumbar scoliosis ≤ 25° Cobb Angle</td>
<td></td>
</tr>
<tr>
<td>• Direct decompression</td>
<td>• Unstable isthmic spondylolisthesis</td>
<td></td>
</tr>
<tr>
<td>• Interspinous distraction</td>
<td>• Direct decompression + coflex®</td>
<td></td>
</tr>
<tr>
<td>• Direct decompression + coflex®</td>
<td>• Direct decompression + fusion</td>
<td></td>
</tr>
</tbody>
</table>

### Treatment

- **Stabilization**
STUDY OVERVIEW

Introduction
In order to demonstrate the safety and effectiveness of the coflex® implant, Paradigm Spine® set out to develop the most rigorous clinical protocol that encompassed any and all questions regarding the possible data gathered throughout the study. In addition to developing a rigorous protocol, Paradigm Spine® wanted to establish the most comprehensive and scientific clinical study practices and conduct.

Study Design and Execution
The investigation was a prospective, randomized, multicenter, concurrently controlled comparison of the coflex® procedure to the current standard of care (posterolateral fusion with autograft and pedicle screw fixation), following surgical decompression in both groups. The objective of this clinical trial was to evaluate the safety and effectiveness of the coflex® device for the treatment of 1 or 2-level lumbar stenosis with or without degenerative spondylolisthesis up to grade I, from L1–L5, that requires surgical decompression, and in patients with at least moderate impairment in function, who experience relief in flexion from their symptoms of leg/buttocks/groin pain with or without back pain, and who have undergone at least six months of conservative treatment.

215 randomized coflex® patients and 107 randomized control patients were enrolled in 21 investigational sites all across the United States.

A follow-up rate of nearly 96% underlines the credibility of the study findings. The primary success criteria was centered around measuring safety of the coflex® device (i.e. evaluating reoperations, revisions and major complications) and its effectiveness (i.e. pain and function before and after receiving the coflex® device). The patient had to demonstrate no safety failures and show improvement in pain and function to be a clinical success.

The coflex® clinical trial was conducted entirely per the United States FDA’s Good Clinical Practices guidance. In order to prevent bias, at no time did Paradigm Spine® have any direct contact with the study data, data analysis process, or outcomes. All data management for this study was outsourced to completely independent, highly reputable third parties. The role of Paradigm Spine® was limited to ensuring each of these parties performed their duties in an efficient and timely manner, as well as coordinating Data Safety Monitoring Board (DSMB), Clinical Events Committee (CEC) meetings, and subject randomization.

Inclusion Criteria
- Back pain with neurogenic claudication with at least moderate stenosis (L1 to L5) at 1 or 2 levels
- ODI > 40
- VAS LBP > 50
- Age 40 to 80
- Six months conservative care + ≥ 1 epidural injection

Exclusion Criteria
- Greater than 2 stenotic levels
- Previous fusion or multiple surgeries
- BMI > 40
- Bone density < −1.0 (Osteopenia/Osteoporosis)
- Scoliosis > 25° Cobb Angle
- Spondylolisthesis > Grade I
- Isthmic spondylolisthesis

Data Collected Within the Study
- Clinical
  - ODI, SF–12, ZCQ, VAS, operative details, demographics, etc.
- Radiographic
  - ROM, disc heights, foraminal heights, bone resection analysis, fusion and lack of fusion, fractures, etc.
- Safety
  - Collection and reporting of any adverse event that occurred during the course of the study

*The scores used during the coflex®-FDA study are questionnaire based scores commonly used in the USA to rate back pain, leg pain, symptom severity and physical function of patients.

ODI Oswestry Disability Index
VAS LBP Visual Analog Scale Low Back Pain
VAS LLEG Visual Analog Scale Left Leg
VAS RLEG Visual Analog Scale Right Leg
ZCQ SV Zurich Claudication Questionnaire Symptom Severity
ZCQ PF Zurich Claudication Questionnaire Physical Function
ZCQ SF Zurich Claudication Questionnaire Patient Satisfaction
SF-12 PCS Short Form 12 Health Survey Physical Component Summary
SF-12 MCS Short Form 12 Health Survey Mental Component Summary
Perioperative Outcomes

The coflex® procedure has proven to decrease the length of surgery, hospital length of stay and, due to its less invasive application, the amount of blood loss during surgery.

Operative Time *(minutes)*

The use of the coflex® device reduced the operative time by 36% compared to fusion.

Hospital Length of Stay *(days)*

The use of the coflex® device reduced the length of hospital stay by 40% compared to fusion.

Estimated Patients’ Blood Loss During Surgery *(cc)*

The use of the coflex® device reduced the patients’ blood loss by 69% compared to fusion.

Percentage of Patients Getting Post-Op Narcotics *(%)*

Fewer coflex® patients needed narcotics 6 weeks after surgery, which was sustained through 2 years, compared to fusion.

Criteria Defining the Composite Clinical Success (CCS)

<table>
<thead>
<tr>
<th>coflex® vs. Fusion</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>W 6</td>
<td>0.080</td>
</tr>
<tr>
<td>M 24</td>
<td>1.000</td>
</tr>
</tbody>
</table>

Overall Improvement After Two Years in ODI

coflex® patients outperformed fusion patients in ODI over the course of 2 years.

Improvement of at least 15 points in ODI

coflex® patients felt significantly better 6 weeks after surgery, which was sustained through 2 years, compared to fusion.

FACT

The study has shown that the coflex® procedure outperformed fusion in nearly all clinical outcome measures at 2 year follow-up.
The study has shown that the associated back pain can be addressed effectively by *coflex*.

**FACT**

More patients were satisfied with the *coflex* procedure compared to fusion.

**Percentage of Patients That Were Satisfied With Outcome at 2 Years (%)**

- *Fusion* vs. *coflex*: p-value = 0.052
- *Fusion* vs. *coflex*: p-value = 0.345
- *Fusion* vs. *Fusion*: p-value = < 0.001
- *coflex* vs. *coflex*: p-value = < 0.001

More patients would recommend the *coflex* procedure compared to fusion.

**Percentage of Patients Who Would Recommend Same Treatment (%)**

- *Fusion* vs. *coflex*: p-value = 0.024

At 2 years after surgery, more *coflex* patients were satisfied with their outcome and would recommend the same treatment compared to fusion patients!
Radiographic Outcomes

The coflex® device has been shown to maintain stability while still allowing for motion in the index level and maintaining physiological adjacent segment kinematics.

The radiographic analysis of the study has been done by an independent core lab (Medical Metrics, Inc.). The core lab analyzed digitalized x-rays that have been taken by the study sites following a binding protocol. Medical Metrics uses a software to analyze x-rays up to an accuracy of 0.1 mm and 0.1°.

**Radiographic Outcomes**

**FACT**

During the study, range of motion and translation were analyzed by a core radiographic laboratory, which found that coflex® preserves index and adjacent level motion compared to pedicle screw fusion!

**Foraminal Height – X-Ray Analysis (mm)**

<table>
<thead>
<tr>
<th>Pre-Op</th>
<th>M24</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.72</td>
<td>17.39</td>
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</tbody>
</table>

**FIXATION** vs. **STABILIZATION**

**Fixation Shortcomings**

- Increased hypermobility in the adjacent segment
- Increased rate of adjacent segment surgery at 2 years
- More invasive and time consuming procedure
- Increased revision and reoperation rates after 2 years

**Stabilization Advantages**

- Stabilizes while preserving motion at the index level
- Preserves physiological kinematics at the adjacent level
- Provides additional stabilization over time
- Allows for faster pain relief (at 6 weeks)

**Interlaminal Stabilization** provides stability without the shortcomings of fixation.

---

*Based on the outcomes of the coflex® Interlaminar Technology PMA (P110008).
Patient Preparation and Decompression

The patient is placed in prone position on a surgical frame avoiding hyperlordosis of the spinal segment(s) to be operated on.

For the surgical decompression as well as for appropriate interspinous distraction, a neutral position or a slight kyphosis may be advantageous.

Paramedian or midline approach is taken with preservation of the supraspinous ligament.

The muscle is sharply dissected lateral to the supraspinous ligament preserving the entire thickness of the supraspinous ligament.

The interspinous ligament is sacrificed and any bony overgrowth of the spinous process that may interfere with insertion is resected.

Importantly: See Surgical Technique Manual for detailed instructions, including all warnings and precautions, that are involved with implanting the coflex® Interlaminar Stabilization™ technology.

Ligamentum flavum is resected and microsurgical decompression is performed, relieving all points of neural compression.

Insertion of the coflex® Implant

Trials are utilized to define the appropriate implant size. The trial instrument is placed to evaluate proper contact with the spinous process and the amount of interspinous distraction. Some bony resection of the spinous process may be needed to ensure proper contact of the implant.
In case of ligament reconstruction, the fascia and the supraspinous ligament can be closed in one layer over the spinous processes. A surgical drain may be placed as per surgeons' preference. Paraspinal muscles are reattached to the supraspinous ligament. Skin is closed in the usual manner.

Prior to insertion, the wings may need to be opened slightly using the bending plier to ensure appropriate depth of insertion.

The implant is introduced via impaction utilizing a mallet.

Proper depth is determined if a ball tip probe can be passed freely leaving 1–2mm separation from the dura.

Once proper placement has been achieved, it is recommended to securely crimp the wings of the implant using the crimping plier.

One Level Implantation

By deeply inserting the coflex® implant at the level of the facet joints, the implant counteracts the majority of posterior column forces (interlaminar positioning).

Two Level Implantation

If a two level decompression is mandated, the coflex® implants must be sequentially placed to the appropriate depth avoiding an overlap (contact) of one pair of wings upon the other. The coflex® device is indicated for implantation at 2 contiguous levels.
**PRODUCT INFORMATION**

**Sterilization Tray**

UAC 00000

**Trials**

<table>
<thead>
<tr>
<th>Color Code</th>
<th>Size</th>
<th>Article Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16mm</td>
<td>UAT 00016</td>
</tr>
<tr>
<td></td>
<td>14mm</td>
<td>UAT 00014</td>
</tr>
<tr>
<td></td>
<td>12mm</td>
<td>UAT 00012</td>
</tr>
<tr>
<td></td>
<td>10mm</td>
<td>UAT 00010</td>
</tr>
<tr>
<td></td>
<td>8mm</td>
<td>UAT 00008</td>
</tr>
</tbody>
</table>

Material: Medical grade acetal copolymer (POM)

**Instruments**

- Bending Plier: UAT 10100
- Crimping Plier: UAT 10200
- Mallet: UAT 20100

**coflex® Interlaminar Implant**

<table>
<thead>
<tr>
<th>Color Code on Implant Box</th>
<th>Size</th>
<th>Article Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16mm</td>
<td>UAI 00016</td>
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<tr>
<td></td>
<td>14mm</td>
<td>UAI 00014</td>
</tr>
<tr>
<td></td>
<td>12mm</td>
<td>UAI 00012</td>
</tr>
<tr>
<td></td>
<td>10mm</td>
<td>UAI 00010</td>
</tr>
<tr>
<td></td>
<td>8mm</td>
<td>UAI 00008</td>
</tr>
</tbody>
</table>

Material: Wrought titanium 6-aluminium 4-vanadium alloy according to ISO 5832-3

The coflex® implant is delivered in sterile packaging.
Spondylolisthesis Cohort Results

Among the 322 patients enrolled in the study, 150 (99 in the cofflex® group, 51 in control group) had a stable (no increase in slip from extension to flexion) up to Grade I spondylolisthesis. The average preoperative slip was approximately 9.2% in both study groups (p=0.999).

This section presents the overall result of the spondylolisthesis cohort of patients.

In summary, cofflex® stabilized the index level spondylolisthesis, with no significant increase in adjacent segment translation. In addition, cofflex® provided superior perioperative benefits and similar clinical outcome results compared to pedicle screw fusion. Interestingly, fusion stabilized the index level translation, but created a statistically significant increase in adjacent segment translation.

FACT

The study has shown that the cofflex® procedure outperformed fusion in nearly all clinical and radiographic outcome measures at 2 year follow-up in the spondylolisthesis cohort! The cofflex® device maintained physiological adjacent segment kinematics at 24 months!

cofflex® patients outperformed fusion patients in ODI over the course of 2 years
cofflex® patients felt better 6 weeks after surgery, which was sustained through 2 years, compared to fusion

APPENDIX A
APPENDIX B

Safety

An independent Data Safety Monitoring Board (DSMB) evaluated the safety profile of the cofflex® study on a quarterly basis to ensure that patient safety was not compromised.

All adverse events were independently reviewed and blindly adjudicated by a Clinical Events Committee (CEC), with their decision binding. All radiographs were analyzed by an independent core lab (Medical Metrics, Inc.).

Table 1: Incidence of Adverse Events cofflex® and Fusion Control Efficacy Evaluable (PP) Cohort

<table>
<thead>
<tr>
<th>cofflex® (N=215)</th>
<th>Control (N=107)</th>
<th>p-values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fracture</td>
<td>5.1%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Component loosening</td>
<td>1.4%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Component migration</td>
<td>1.4%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Component breakage</td>
<td>0.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Component deformation</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Hematoma</td>
<td>0.0%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

83% of patients in the cofflex® group and 75% of patients in the fusion group, who had spinous process fractures observed by the radiographic laboratory, did not have any associated symptoms at the time the fracture was observed. Table 2 and Table 3 detail the incidence of spinous process fractures in cofflex® and fusion patients.

Spinous Process Fractures

Spinous process fractures were observed by the core radiographic laboratory in 30 cofflex® patients (14.0%) and 8 fusion patients (11.9%) of patients with spinous processes retained by partial laminectomy. Spinous process fractures were also observed by the investigator surgeons. The incidence of fractures observed by the surgeons differed from that observed by the core radiographic laboratory, as 8 surgeons differed from that observed by the core radiographic laboratory in 30 cofflex® patients (6.3%, 12/192) and 12 additional reoperations or revisions in 10 fusion patients (10.1%, 10/99). One of each of the cofflex® and fusion revisions was in a patient who had a reoperation prior to 2 years.

Between 24 months and 48 months of follow-up, there were 13 additional reoperations or revisions in 12 cofflex® patients (6.3%, 12/192) and 12 additional reoperations or revisions in 10 fusion patients (10.1%, 10/99). One of each of the cofflex® and fusion revisions was in a patient who had a reoperation prior to 2 years. Based on available patient data through 48 months, the cofflex® revision rate is 15.8% and the fusion control revision rate is 15.9%. The analysis of the data from follow-up beyond 24 months was not considered in the approval decision for the cofflex® device.

By month 24, 48% of the cofflex® spinous process fractures were resolved. Of the unresolved spinous process fractures, 75% were asymptomatic and resulted in no clinical sequelae or loss of foraminal height during the study. None (0%) of the fusion spinous process fractures were resolved by month 24 and 75% of these patients were asymptomatic.

The adverse event rate associated with spinous process fractures was not significantly higher than that of patients without spinous process fractures. The long-term effects of these spinous process fractures post 24 months are unknown.

The cofflex® IDE study has demonstrated that an over-decompression can destabilize the spine or possibly lead to subsequent spinous process fractures. Especially the resection of the spine to ≤14mm can increase the incidence of postoperative spinous process fracture. Other possible predictors for spinous process fractures are the height of the spinous process ≤23mm preoperatively, “kissing” spinous processes, or poor bone quality.

Revision

Table 2: Spinous Process Fracture Incidence in the cofflex® IDE Study

<table>
<thead>
<tr>
<th>cofflex®</th>
<th>Fusion Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/N</td>
<td>%</td>
</tr>
<tr>
<td>Spinous Process Fracture</td>
<td>30/215</td>
</tr>
</tbody>
</table>

Table 3: Time Course of Spinous Process Fracture Incidence in the cofflex® IDE Study

<table>
<thead>
<tr>
<th>Group</th>
<th>Time of Initial Fracture Observation</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>cofflex®</td>
<td>Post-op 6 W 3 M 6 M 12 M 18 M 24 M</td>
<td>30</td>
</tr>
<tr>
<td>Fusion Control</td>
<td>4 2 2 - - - -</td>
<td>8</td>
</tr>
</tbody>
</table>

*3 out of the 5 observations at 24 months had unreadable or missing 6 week, 3 month, 6 month, 12 month and 18 month X-rays.

Through 24 months, the reoperations and revisions in the cofflex® group included 5 irrigation and debridement procedures (including 1 cerebrospinal fluid leak), 2 supplemental decompression surgeries retaining the device, 2 revisions for cofflex® removal & replacement, 2 decompressions and device removal, 1 debridement and device removal, 13 (6.0%, 13/215) conversions to primary fusion.

Two patients had a reoperation prior to a revision. There were no revisions related to device breakage.

Between 24 months and 48 months of follow-up, there were 13 additional reoperations or revisions in 12 cofflex® patients (6.3%, 12/192) and 12 additional reoperations or revisions in 10 fusion patients (10.1%, 10/99). One of each of the cofflex® and fusion revisions was in a patient who had a reoperation prior to 2 years. Based on available patient data through 48 months, the cofflex® revision rate is 15.8% and the fusion control revision rate is 15.9%. The analysis of the data from follow-up beyond 24 months was not considered in the approval decision for the cofflex® device.

There were no statistical differences between the cofflex® and fusion groups with regards to the rate of any severe complications, device related complications, or surgery related complications.

However, the revision rate in the adjacent, non-operated segment was significantly higher with the fusion patients.