Alright, everyone, uh, really thrilled
to welcome back Scott Kirkland.
He's the co-founder and CEO of Envision.
We've spoken to Scott a few times before.
I think a lot of us know the business pretty well.
Uh, we do have a bunch of new members though,
and so if you are new to the story,
the high level view here is that Envision is developing
or has developed a couple of different, uh,
portable brain scanning devices.
So, uh, these aren't a replacement, uh, or,
or pretend to be a replacement to things like MRI.
These, uh, devices excel in other areas that namely,
they're faster, they're cheaper, uh, they're portable,
they're smaller, uh,
and that's really a big deal when it comes
to treating brain injury, uh, particularly, um, you know,
beside the bed or in ambulance
and with first responders, et cetera.
Um, the company's not yet at the commercialization phase,
but we are getting very, very close.
And 2026 is shaping up
to be a very interesting year here as well.
Uh, the companies, uh, did a, a raise towards the end
of last year, so it's cashed up, it's got the tech,
we're waiting for some regulatory approvals
and things will probably move pretty fast, uh,
once we hit that stage.
So this is a great time to catch up

and I'm really, really thrilled

that Scott could make the time to do so.

Um, very quickly, none of this is advice.

If you do have any questions, use that Slido link, uh,

and we'll get right to it.

Scott, thanks for joining us.

Pleasure to be here, Andrew. So,

did I get that more or less right?

I mean, 2026, it's a, it's like these are, I think I've said

to you last time, these, these, uh,

particularly in medi med tech, you know, it's,

it's often the company that's sort of the overnight success

that's 10, 20 years in the making, but,

and it's, it's always a bit of a journey,

but it, it feels as though it feels though this is a,

this is gonna be a pivotal year for you guys.

Yeah. And, and it's, yeah,

it's been an eight, eight year journey.

I, I, I think just focusing on your comment

that FDA approval and,

and that's obviously a major inflection point.

We can sell product thereafter, right.

And we are running a, a pivotal trial right now recruiting

to, uh, support an FDA de Novo clearance.

Mm-hmm. But I think, you know, so the FDA approval's,

a big building block reimbursement in the us, you know,

securing, that's another huge, huge building block.

But I think a pivotal trial and the,

and the readout is really the first time you were
demonstrating that the product works safely
in its intended use population Yeah.
With pre-specified endpoints in a
statistically significant manner.
Yeah. So I think there's a pretty strong argument that
as the pivotal trials, the primary source of data
for the FDA, that could be as big a inflection point
for the business as the FDA clearance itself.
Yeah. It obviously opens up.
Is that because, sorry, sorry.
Is that because it, I I I mean nothing is a done deal
until it's a done deal.
But I mean, once you've sort of got really good data from
that, it feels as though it's largely for want
of a better term, a box ticking exercise to get there.
It'd would be very unusual to get good data
and for them to reject, I suppose. Correct.
Yeah. Correct. I it removes that layer of uncertainty.
Nothing is ever guaranteed in this world. Of course. Yep.
But it certainly significantly decreases that uncertainty.
So the uncertainty around the FDA approval point,
but also what it may open up beyond that.
Yeah. Whether it's partnering opportunities,
acquisition interest, you, you name it.
So, uh, it also
will typically propel the visibility of a company.
It gives you a large data set to go
and talk about at the major stroke,

international stroke conferences, et cetera. Yep.

Now, you mentioned de novo before as well.

So those who aren't in the game, this is, this is, um, uh,

for, for products that have no precedent, right.

This is a, an entirely new category of device,

which is great in the sense that there's sort

of no competing sort of, uh, ult alternate sort

of product out there.

Uh, but,

but you know, also, um, it, it means

that there is, there is a much more stringent sort

of regulatory sort of hurdle proof

of evidence that is required.

But then once you guys,

and I know you've got various sort of types

of devices out there, it becomes a much more streamlined

process after

that de novo clearance has sort

of been granted. Correct? Yeah,

Yeah, yeah.

Absolutely. So there's, there's more heavy lifting,

and I think we touched on this a little bit last time.

You're proving safety and efficacy from first principles.

You also create a line in the sand.

So the, the, the most common FDA approval pathway is the

five 10 K, which I'm sure you, you know,

may have had portfolio companies that have gone down

that pathway before demonstrating substantial equivalence

to something already in market
that it's as good or better than.
Yeah. Now, once you secure de novo,
any prospective competitors coming along in the future
that want to market under, you know,
a similar intended use statement, they need to prove they're
as good or, or better than your technology.
Yeah. So you are creating a, you,
you can create a very high bar, which is
what our part of our intention.
And then yeah. As, as you described,
the next generation miniaturized version,
or we're piggybacking off the de novo,
and then it's a five 10 K, so it's a quicker review.
The body of evidence required is, is much smaller
because we are then demonstrating as good
or better than the precedent product of ours.
Yeah. And, and obviously we design our next generations
to be superior to the one prior.
Yeah. Nice one. Now, um, I mean,
obviously there's a bit of confidence in house.
I mean, you've taken steps. We touched on this last time,
you know, with, uh, the expansion
of your facility at Macquarie Park to, to ramp up, uh,
production, there's some strategic partnerships in place.
So there's, there's sort of a lot of confidence there.
Can you speak to the source of that?
Obviously we've had, uh, we've had various sort of trials
and, and things in, in the past,

but just expand on that for someone who's sort
of looking at this going, well, why, why is it that you're
so confident that, that this will eventually, um, be passed
and that you'll be able to be in market?
Yeah. So there, there's a lot
that has gone into the r and d to date.
So we mentioned eight, eight years with Envision, you know,
that that figures north of $60 million now between equity
and, and, and grants and rebates, et cetera.
And there was close to a decade at the
University of Queensland.
I think Australia has a great reputation
for exporting World First ip.
Um, it, it, it is genuine world first.
There is a very unique value proposition,
and you can see there's a huge amount
of investment in acute stroke care as well
because of the burden of stroke, which you Yes.
Which you touched on, you know,
recently Boston Scientific acquired, um, penumbra,
which have a very large kinda neurovascular portfolio
to treat strokes.
Uh, and that was a rather rather significant transaction.
Mm. Uh, you know, in other, in, in,
in other categories you've seen, you know,
Medtronic recently invested on a circuit US 90 million in an
Aussie MedTech doing something kind
of innovative in the cardiac space in a pivotal study.

And Australia's got this great reputation for, for,
for generating this ip.
We have some promising clinical data behind us.
You know, we've run a series of, of, of studies
and, you know, we've got some best, I,
I guess best in class clinical partnerships.
Uh, you know, we talked about many
of the sites we're collaborating with for our pivotal, uh,
the new addition since then, um, was UCLA as well,
which we added on late, late last year,
which is another great site.
Yeah. Uh, in, in Los Angeles.
Uh, got the Australian Stroke Alliance, we, our Mayo Clinic.
Um, and then, you know, Keysight technology,
so this is our long term supplier product collaborator.
Uh, again, not a name many people are familiar with, uh,
but they are a, a, a world leader in test
and measurement, I would say the best in test
and measurement solutions.
Um, their market cap's about 36 billion US
still in New York self exchange.
Yeah. Uh, and,
and they've invested close to $20 million in ambition
because they believe in our investment thesis,
they've done their own due diligence.
Um, I think that's a pretty powerful signal for a business
of that size to pay attention to a little Aussie, you know,
little Aussie butler.
Little little Aussie. Yeah.

Yeah. No, very, very much so.

Yeah. Yeah. Yep.

Um, you know, one of the other interesting things as well,

so, you know, we, we've spoken to a, a number of sort

of companies in this field, uh, before,

and, you know, sometimes you're dealing with sort

of very rare conditions

and treatments, not that to,

to diminish their importance at all.

But I think one of the things that's

interesting about Envision is that the,

the addressable market is just ginormous.

Like stroke is one in four adults will experience at some

point in time, which is, which is, um, uh, just sort

of shows you the, the, the size of the potential.

I think the other thing that we've hit upon in previous

meetings is not only is that the, the, the fact,

but also there is a very wide recognition

of it being a very serious, uh, uh, issue.

And there's a lot of re there's a lot of government, uh,

support, which we've talked about Yes.

Before in terms of getting rebates.

So I know that that's just, I put that out there

because I know a lot of other companies sort

of really str bang the drum to sort

of say, no, this is important.

It doesn't feel like that's so

much of an issue for you guys.

It's, it, we, we certainly do benefit from, from
that notion that it is well understood.
Lots of people have a friend
or a family member that's experienced a stroke.
People can relate to it, like you described.
It's not, not some obscure rare indication.
So we are very fortunate, whether it's grants
or investors, it's an easy story for people to get their,
their head around and relatable.
So certainly we, we, we, we do benefit from that.
Um, but in terms of the grant programs, you know, retaining,
manufacture, creating engineering roles,
tackling big health, economic burden,
tick, tick, all those boxes.
So, uh, we did, we did win a few, uh,
one more I think since we last chatted,
which was a $3 million, um, CRCP funded
regional benefits grant.
That's right. Which, which is interesting of itself.
It's not an r and d grant as such.
It's, it's demonstrating the real world benefit
of deploying our EMU device,
our in hospital scanner in regional settings.
And we're talking about regional South Australia,
we're talking about some pretty small hospitals.
They don't have all the resources
of a Royal Adelaide, for example.
They need to make some pretty timely decisions.
Do we keep the patient here? Do we need to transfer them?

And there are very long transfer times.
They can be risky, clinically risky, costly, um,
and the CT axis can be sporadic.
They don't necessarily have, um, onsite neurology expertise.
So we're, we're designing a study supported by this grant
to show when we deploy an emu, when head
with telehealth connected to telestroke, yeah.
How can we reduce the time to diagnosis, time to treatment,
make better informed, more efficient transfer decisions,
which can be very, very costly to give us measurable health,
economic and patient benefit data.
And also how this fits into the workflow
to support reimbursement, support marketing of the product.
Yeah. So this is quite a different study,
and we would run a similar study in the US
to support driving adoption beyond the early adopters.
Yeah. You know, there, there's always gonna be a cohort
that are super enthusiastic clinicians that have a bit
of sway in their institution that can, you know,
maybe maybe convert for a pilot,
but to drive that real momentum shift.
It's really around this benefit data.
How does it, how does it drive efficiencies, savings,
you know, obviously patient benefit,
how it fits into the workflow.
Then obviously the reimbursement piece as well.
What's the economic
Actually speaking, speaking of the reimbursement, uh,

benefit, uh, there as well.

I, I did, uh, see that you

pursuing the new technology add-on payment in the us Yeah.

Um, explain that for, for people who aren't familiar.

Yeah. We might lose half the audience

'cause it's not the most exciting topic,

but, um, that's okay.

There might be here, here for this level of detail.

Well may maybe the bottom, the bottom line is,

is less boring, I suppose.

Okay. So I'll try and get to the point.

But the, the way, uh,

strokes are typically reimbursed in the US is under

something called an ms DRG

or disease related, um, group payment.

And those payment buckets are designed to cover the majority

of the hospital's costs, uh, excluding physician time,

but device bed stay, et cetera.

They, those payment buckets will vary depending

on the type of stroke.

Is it ischemic, is it hemorrhagic if it is treated or not?

What type of treatment, you know, uh, thrombectomy,

a surgery has a higher payment bucket.

If there are higher complications,

there's a bigger payment bucket, et cetera.

Mm-hmm. Those payment buckets are

devised utilizing historical usage data, what is needed

to care for these stroke patients.

And if you are a new product

or you have no usage data, right.
So, you know, the hospital gets their 50 k payment
for this thrombectomy with major complications,
they're gotta try and squeeze your product in on the
argument that maybe it's gonna save money, maybe it's going
to, you know, reduce length of stay
or free up imaging assets or whatever it may be.
Yeah. So the intention
of the new technology add-on payment is
to provide an incremental payment beyond the DRG bucket
for the use of your product for two to three years
to then create a, his made of remove adoption friction and,
and B, so you have some usage data,
so the DRG payments can then update to reflect the usage
of your device.
Yeah. And the way to satisfy INTAP three criteria has
to be newly FDA approved.
Mm-hmm. There are certain cost criteria,
and then the, the kicker,
the real important element is you need to be able
to demonstrate substantial clinical improvement.
Yeah. And there are two ways you can do that.
One, you can run a benefit study,
which is not too dissimilar,
what we discussed about the study in, in,
in regional South Australia,
and there's a company in the, um, AI solution in,
in the stroke space called V AI that has done just that.

And they were able to demonstrate
to workflow tool triage notification from ed arrival
to notification of the interventional team who need
to then perform the surgery
for this particular type of stroke.
They could s save on average is around 15 minutes. Right.
And we know time is everything in stroke, it's,
it doesn't sound like a lot, but 15 minutes is huge.
A lot of brain cells, right? Yeah.
And, and, and so they were able to secure the,
the intap payment.
And so you run a benefit study, clear endpoints,
meaningful improvement.
Yeah. And that could just be time to diagnosis, for example.
Yeah. The other opportunity is if you secure
FDA's breakthrough device designation, well,
the substantial clinical improvements assumed.
So you don't need a completed benefit study to obtain it.
Interesting. Now, you would likely want a benefit study
to ensure that there's a whole lot of extra evidence
to support the marketing of the product.
Mm. But it, but it means you can get out the gate from
that FDA approval early doors, you can get
that extra payment, which is certainly helpful.
Yeah, definitely. A anything that can reduce the barrier
to purchase is, is definitely a good thing.
Yeah. Um, absolutely.
Um, let me just, I'm gonna,
rather than wait till the end, they're still here.

They haven't dropped off after the reimbursement. No.

Well, we're, we're, we're,

we're here for it, Scott, don't you worry.

Don't worry. Okay. Um, uh, we,

we'll nerd out on this stuff all day long.

Okay. Um, uh, I, I, I'll just,

I'll just go to a couple questions here.

Actually. This is more of a comment than a question,

but it's a pretty filled, well,

I was gonna say a, a, a, a good story in a way,

but, um, not, not diminishing the severity of the news here.

Let me just read it. Not,

he said my dad had a stroke last Friday, so

that's why I don't wanna frame it as good news.

But he was one of the lucky ones who found one

of the two mobile units in Melbourne that allowed treatment

to begin immediately.

So, uh, more, as I say, more

of a comment than a question, good luck with your mission.

The sooner a diagnosis can be done in

every ambulance, the better.

I mean this, thank you. This, this is

the whole point of it. Right.

Incredibly lucky. Incredibly lucky.

I think there's only 60

or 70 mobile stroke units globally, something like

that. I mean, there's only two And Australia,

Globally. Yeah.

Globally, yeah.

Right. And, and yeah. Incredibly lucky. And, and yeah.

The outcomes they're generating are amazing.

They turn up to people's homes,

they give 'em a CT scan in the driveway.

These patients, many of them have severe symptoms.

They can't speak, they can't move their left arm. Yeah.

They get scanned, they get treatment

and, you know, a few hours later it's

the symptoms of reverse.

So, um,

the challenge is the ambulance is about a

million dollars for the kid out.

Yeah. And then it's another million

dollars to run each year.

Yeah. Yeah. So, you know, what we're trying to do

with our model is, well,

we can have the scanner in the backpack

and we don't need a radiographer on board.

A paramedic can run it, and we plug in through telehealth

so we can still get expert neurology guidance

and make every ambulance essentially capable

of delivering a similar level of care.

Yeah. And just to put the cost into perspective there,

um, relative to the ambulance here.

Yes. We're talking for a first responder device of what,

50 to a hundred us? That's

Right. Yeah. Yeah.

It's plus Pretty cheap plus consumables, but Yeah.

Yeah. It's, it's, yeah.

Uh, excellent. A fraction.

And the way we like to think of, it's a bit like

ECGA point of care test.

The, the, the ideal in opening the door

to infield treatments, whether it's blood pressure

management for hemorrhages, reversing blood thinners

for hemorrhages, uh, clot busting drugs for ischemia, we,

you know, long-term goal.

And then also, where do we take this patient, you know,

we might need to bypass the nearest hospital

'cause they need surgery for some to, to pull the CLO out.

Yeah. So, Uh, yeah.

Sorry. Sorry. No,

No, that's it. That was the end of my point,

but yeah. Okay.

Slight lag. Um, uh, previously, uh, just off air

before we started, you, you asked me about ai,

it is the topic jour at the moment.

So, you know, I I I wouldn't normally raise it except

that it strikes me that envision this is like,

AI just is great at images.

Right. And it also feels as though there's not a huge amount

of additional work,

or even work that needs to be done

in particular to envision.

It's almost like a third party can develop, uh, uh, products

around the images that, that you throw off.

Is it, am I barking up the wrong tree there as well?

Or is it, is, is the AI seen

as a real enhancer for what you've got? It,

It's a, it's a bit different

because we, we don't do post-processing,

whereas AI analyzing an image,

we use AI at a, at a signal level.

So yeah, for our in, in hospital device emu,

we have 16 antennas, uh, a wide frequency range.

Mm-hmm. The signals are incredibly complex. Mm-hmm.

For the first responder, we have 28

antennas, even more complex.

So we need AI to make sense of those signals

to arrive at a diagnostic output.

Mm-hmm. Right. So it is, it is quite, quite different.

And the way we, um, the way we started

that journey is we developed a simulation pipeline

where we could put in the design the simulation software,

we can put in the design of our antennas mm-hmm.

Real world design. And we could insert, um, A MRI template

of a human head, healthy heads, unhealthy heads,

and train algorithms in a simulated environment.

And so we, again, you said your audience wants to nerd out,

so I will indulge them. Please

Do, go For it.

We can take the, um, MRI template

and go through all the tissue types, gray matter,

white matter CS, F,

and convert them to the dielectric values, which is the,

the measurements that we are interested in,
what our system looks at.
And then we can insert a bleed artificially
and the dielectric value for a bleed
that should not be there and ruptured blood vessel,
and then run a scan and we can, we can do a bleed that's,
you know, one mil, half a mil, five,
10 shaped like a golf ball, what, whatever, any different,
you know, um,
possible permeation you could imagine in that simulated setting.
And so in that environment,
we would get a hundred percent sensitivity specificity.
Great. But it's a simulation.
It's not, it's not the real world.
It's close, but it certainly gave us confidence
to then proceed to the next step,
which is the real in world, in human, um,
training the model, then testing the model.
But I think, you know,
and I was having this conversation the other day,
and I would suggest AI and healthcare's no longer novelty.
It's literally part of the infrastructure.
Every comprehensive stroke center that we talk
with in the US uses it in their stroke care workflow.
Yeah. Interesting. Yeah.
Um, uh, lemme go to wonder, Alex, uh, from Alex here.
What's the timeline of the current pivotal trial?
What steps would be required

after that leading to FDA approval?

Yeah, so we're, we're targeting to wrap that up, uh,

around the middle of this calendar year.

Mm-hmm. And it's, it's ramping up nicely.

We have seven hospitals currently recruiting.

We have an eighth hospital, Memorial City in Houston,

also going live this month.

Mm-hmm. Um, there is a kind of analysis phase, matter

of weeks to months should not take too long.

Mm-hmm. In, in the background, there is a technical file,

so a dossier that we submit to the FDA,

the results from the trial slot into

that dossier, and then it's submitted.

There's an interactive review with the FDA, um, you know,

their public review times anywhere from nine to 12 months.

There's questions along the way. There always is.

That's how it works. Yep.

Uh, and from that FDA submission,

we're building out our go to market.

Yep. So it might be a medical affairs liaison in know,

clinical field operations.

Uh, we, we've talked a lot about targeting the stroke belt,

particularly states like Texas, Florida,

and doing a concentrated launch somewhere like Houston,

we don't need five or six sales reps.

We could cover that region of one

to two sales reps in the first couple of years.

So it's really a considered, um, kind

of expansion of the go to market.

Um, whilst we're waiting for clearance,
and obviously we would be working hard working to try
and convert a few of the trial sites to pilot sites, which,
which you can, you can establish MOUs
or letters of attempt subject to FDA approval. Interesting.
Yeah. Um, uh, so let,
let's assume the FDA approval comes through.
There's, you often, as I understand it, hospitals have to go
through their own review process.
So that's, you know, there's a bit of bureaucracy there
that, that, that can take a little bit of time.
But then there's also, um, doing a bit of training.
So this isn't a eight year medical, you know, PhD,
but there is sort of training and there.
So can you give us just a sense of, of the time, you know,
US investors, we're always super impatient.
We want it to happen tomorrow,
but it, I think it's important to sort
of set expectations here. Like Yeah, I,
I, I, look, I think the good news is the training is the,
the shortest part of the sales cycle installation
and training, that's relatively quick.
You know, training can be done to, I mean, at least
for the trial in a couple of hours, right?
Right. It is. And there's video refreshes
and other things, other materials that we've, we've created.
Yep. The longer part
of the procurement cycle is typically the, the review

by value analysis committee or vax.
Yeah. Right. So obviously it's help if you have a head
of neurology or a head of ED
or ICU that has a bit of sway that can walk down
and I really want this, that is helpful.
But at the end of the day, there's, you know,
a financial controller.
There's, you know, it might be an economist in some way,
you know, shape or form having,
having influence in this decision making.
And it's the outcomes
and the data from the benefit study
that will ultimately drive a positive outcome
in those VA reviews.
Yeah, absolutely. So that's really the key element
to be sure we have a really compelling folio there of data
to provide a, a, a that, um, as part of their review.
Yeah. I mean, it, it, it sounds almost cynical to sort
of say that, you know, it's not just about the patient.
It's like, well, yes it is,
but also it's gotta make, there's,
there are economic constraints on these
medical institutions.
Yes. And they, they,
they have got the bean counters like we all do.
And they, it just makes the process
that much easier if you can say,
yeah, you can save a bunch of lives.
That's great. You can improve quality of life. Yes.

That's great too. But you'll save money as like,
now I'm interested, right? Yeah.
Yeah. We save money
and Oh, you'll make money now. I'm really interested, but
Again, now I'm interested. Yeah. You,
You know, we're really talking about
the US experience here.
There are other markets where we would
expect slightly less friction.
Yeah. Um, our own market.
But also, um, when we were in Dusseldorf in November,
uh, we were invited to spend a bit of time in Oslo, uh,
with, you know, leaders in stroke from across the country.
Some, some, you know, excellent engagement
there and opportunity there.
Uh, same in, in southern Germany as well.
So, um, you know, Europe is an interesting market in
that it's just pressure.
It's all so different. But Nordics, Germany are a fantastic
kind of avenue into greater Europe in in the future.
Um, well-funded early adopters.
Um, and we've got some great existing relationships, number
of which have come by the
Australian Stroke Alliance as well.
You know, everyone knows everyone on these, you know,
these international stroke meetings
and, um, so there's great connectivity there.
But yeah, it's, it's, it's a, it's a shame how the,

the healthcare system is, is is structured, unfortunately,

but that's just, that's just reality. We live,

It's the nature of the base. Yeah.

Yep. For sure. Um, lemme do a couple quick fire ones.

'cause I'm, I'm mindful of the time here.

Uh, so I got one from Nick here.

Uh, if the main product range is still

pre-commercialization, what are AMVs

revenue sources at the moment?

A SX page shows four years

of revenue ranging from four to 11 million.

They'd just be the grants, right?

Grant inflows and r and d rebates. Yeah. Yep.

Yep. Excellent. And so, yeah,

and uh, uh, just to mention,

we were expecting mention this enough also expecting our r

and d rebate, you know,

near term this quarter. Yeah. Great.

Yep. Non-diluted funding. It's the best. Um,

It is indeed. Yeah.

We, we love that. Um, uh, one more from Nick.

How was the first, how was the study on first responder MSU

going, uh, just referring

to the September, 2025 announcement?

Yeah, so that's, that's the environment

where your member was discussing their father was

actually getting scanned.

And I don't, I don't know if your,

if if his father was recruited into the study or not.

I, I, I, I don't know.

But, um, it's, we have two stages to it.

Stage one is kind of workflow in implementation, kind

of lower acuity patients and then stage,

and that's tracking well, so I expect to be able to,

you know, report an update on that this quarter as well.

And then stage two is a, a data collection alongside the ct

and we can use that to train

and evaluate the models that we've created

for the first responder device.

Mm-hmm. So, um,

that's a really interesting environment to run research.

'cause like I said, there's not many mobile stroke units.

Yeah. So we're really lucky to be able

to put our device in there

and get these really hyperacute scans.

This is way before anyone turns up

to an emergency department.

They're literally scans done in, in,

in someone's heart. Yeah.

Yeah. Amazing. Um, gosh, time's, time's already run out,

Scott, that what didn't I ask you

that I probably should have asked you?

I know you're probably sick of answering the same questions

again and again from investors,

but there's o often when you sort of, particularly

after I, I, after interviews, you speak to people

and goes, it's always interesting

that no one ever asks me about this,

or, you know, I really see this as a big deal,

but, you know, the, the market doesn't

seem to get it or Yeah,

Yeah. I, I,

you, you know, that conversation, uh,

is always the why now, why don't I wait for FDA approval

or why don't I wait when they've sold 200 units and Sure.

Um, I, I, I think our conversation around the Pivotal trial,

uh, and, and how much of a building block

that is, I think is important.

Um, and you know what,

my former colleague had a had a funny saying, you know,

one day you can be the rooster, the next,

you're the feather duster.

Yes. And then before you know it, you're the rooster again.

You know, it's med tech's very cyclical.

Uh, I think we're starting to see some,

particularly on the industry front, starting

to see some really strong enthusiasm

and investment come into the stroke space as well.

So, yeah. Let's see. Yeah. Yeah.

I'm opt I'm optimistic over the next, over,

over the next coming years. Yeah.

Yeah. Fantastic. Well, look, um, as I've said

to you previously, I mean, we wish, we wish all our guests,

uh, all, all, all of luck.

I was just speaking to one of our members off air about

how hard business is, you know, it's hard, right?

Um, and so that, that, that definitely, um, uh,
is relevant here, but especially
so I think when you're dealing with something
that can genuinely not only improve, uh, you know,
lives, but save lives, you know, it's sort
of like there's an extra dimension to it.
So, mm-hmm. Um, I know you've got a bit
of support here at Strawman.
We do appreciate, um, keeping us up
to date, pleasure, and, um, yeah.
We'll, we'll touch base again next year
and we're just, just fascinated to see how the year unfolds.
Yeah, absolutely. Thanks Andrew.
And I'm, I'm sure I'm more than happy for you
to share my details if any
of the members have more questions
that they didn't get a chance to ask,
wanna follow up with. Oh,
Great. That's fantastic.
Excellent. Thank you
So much. Thanks everyone. Cheer.
Cheers.