Okay, everyone, uh, welcome.

We've got a good one for you today.

I'm really thrilled to welcome Tom Sperling.

He's the CEO of Nova Eye Medical.

EYE is the ticket code here.

Uh, this, uh, a technology company

that's focused on the global glaucoma market.

This is a horrible disease.

It's the leading clause of blindness.

It affects more than 80 million people worldwide.

Their focus is their eye track advanced product.

It's a very highly engineered, illuminated microcatheter.

It's the smallest in the world.

And a surgeon uses that essentially to go inside the eyes,

natural drainage canal, to clear blockages

and restore, uh, fluid flow.

In a moment, I'll show you a very short video that's sort

of, you know, a picture's worth a thousand words.

That'll, that'll give you a clear idea

of what's sort of happening here.

And I guess the, the, the key thing

to remember is this is very distinct from traditional

approaches, which generally leave a bit of hardware,

uh, behind in your eye.

So like a stent or something similar like that.

Whereas we're talking about something that's implant, uh,

uh, free and also restorative.

Um, the company's been around for a long time.

In fact, you can go all the way back to 1985.

Back then, primarily focused on sort of laser eye treatments

for glaucoma and cataracts.

You may know or have come across the company in a previous

incarnation is LX Medical Lasers.

Uh, the history here is

that I believe a little over 10 years ago, they acquired,

uh, the iTrack microcatheter tech

for only about 3 million or so.

And then in 2020 when all in on this technology actually

divesting the legacy business, raising a bunch of cash.

And look, it's still early days,

but it seems like it's, it's a move

that's paid off revenue's more than doubled in that time.

And as has been noted, I mean, you look at the last, uh,

six consecutive halves,

and we're looking at compound annual growth rates that, uh,

that are well up there as well.

And interestingly enough, the company right on the cusp of

that break even point as well.

So I, I couldn't really think of a better time to,

to catch up with Tom and,

and can understand the interest

that's been generated on the forums.

Um, before I welcome, uh, Tom, very quickly to the screen.

It's always important for us to stress.

None of this is, is financial advice.

We've had a bunch of questions come through,

but if any more come up, uh, during the, uh, discussion, make sure you use that Slido link

and I'll, I'll put it to Tom when we get the chance.

So with all that outta the way,

Tom, thanks for your time today.

Thanks, uh, thanks very much for having me, Andrew.

Um, uh, pleased to be here.

Um, so let's, as promised,

I'm just gonna play a very short video here,

and this will just sort of give everyone a bit

of an overview as to exactly what we're dealing with.

Uh, bear

with me that coming through.

Okay.

Uh, yeah, it looks like

It. Uh, excellent.

Excellent. All right. Yeah. There we are.

There we go. Let's do this.

So, Welcome to welcome

to Give the narrators commentary.

Oh, okay. Yeah, if you want. Yeah.

Here we have a very small catheter being inserted into

that main irrigation canal in the eye, there is a picture

of the catheter going into it.

That's the handpiece. The blue piece is a slider.

Uh, and then we have a, you know, a

what we call a visco injector that pumps in, uh, vis,

um, biocompatible hydraulic fluid.

Um, it's called viscoelastic,

but the idea is that that device, um,

that device has three components to it.

It has a light, a pipe,

and a piece of nitinol wir in it

that gives it enough pushability.

The wire gives it some pushability.

The pipe transports transform transports

the biocompatible hydraulic fluid,

and the catheter makes its way around

and the doctor can see where he

or she is with that light under the microscope.

So we have the navigation, it's a, it's a safety

of navigation so that that catheter, um,

effectively clears the canal.

And with the viscoelastic, it, it, um, flushes, um,

the, um, blockages within that canal system.

Glaucoma is a failure of plumbing.

It is just a failure of just, I shouldn't say just,

it is a failure of plumbing.

Uh, tissue gets blocked over time.

We clear that and let the viscoelastic, uh,

open the catheter, open the, uh, uh,

oculus structures back up, and then allow,

that allows the liquid rich protein in the eye

that's flowing through to flow naturally

through those struc structures that were

otherwise, um, blocked.

Uh, failure to treat glaucoma causes a buildup in pressure,

and that pressure ultimately can crush the optic nerve.

And we silently lose our vision from the periphery in, um,

there is no pain associated with this.

Mm-hmm. Um, our therapy, um,

someone usually diagnosed early with, uh, with glaucoma, uh,

is diagnosed having shown up at the optometrist who, um,

get reading glasses when ordinary glasses.

And that, uh, it used to be a puff of air,

now it's moved on a little bit.

You can't even feel it to measure the eye pressure.

And the optometrist will say,

your pressure's a bit higher when essentially an

to an ophthalmologist mm-hmm.

The ophthalmologist will,

most likely the simplest way early on

to a newly diagnosed is to give them drops.

That's not necessarily the best way forward,

but patients go, I can take drops soon.

Patients are tired of taking drops, um,

because you're, take one drop, take another drop.

They're hard to remember.

Our, um, the idea of interventional glaucoma surgery

or interve glaucoma, which is the business we're in,

is about treating the eye, um, with a surgical procedure

to remove the reliance or reduce the reliance on drops

and improve the quality of life.

So rather than just bathe the eye

and drugs every day, we get

that system flowing again in a natural way.

That's, that's the principle we're working with.

And patients,

and I'll, I'll, I'll just go to the basic offering mm-hmm.

People that a big part of glaucoma cataract surgery,

cataract surgery is the world's leading number one surgery

of all surgeries, not eyes of all surgeries.

Right. 20% of patients that roll up with a need

for a cataract surgery also have glaucoma.

That's the dynamic. So that means a doctor who is treating

a a patient can't see

because they've got opacification of our lens, which is, uh,

usually through age and sun and stuff.

That's what, um, uh, cataracts are.

We go in very, very simple operation to remove

that opacified lens

and replace it with a new artificial lens.

Mm-hmm. The doctor will say,

I see you're on two drops a day.

The patient says, I really dislike those drops.

So the doctor says, okay, while we've got you under a line

and aesthetic, and you're on the,

and you're on the, uh, table, I'm gonna do a, uh,

a restorative procedure, try

and clear those blockages, get you off those drops.

We'll also change that lens while we're in.

So we'll come out, the best case scenario is you can see

better and you're not taking drops every day.

That is the principle offering that we have.

So, Tom, that it sounds like a, this isn't,

you go into hospital for a week or anything like that, that
No, it's usually day surgery. Yeah.
Yeah. Really interesting.
And, um, I, I should have mentioned this in the introduction
of course as well, but it's probably implied by the cell.
This is, this has got all the apparent clearances.
We're out there, we're selling devices,
and the nature of the device itself, this is a, a,
a single use device.
Yes. So that catheter we saw in the video
is a single use device.
So it's sterilized and, uh,
placed into the doctor's hands in an operating theater.
It's undone, uh, you know, in the sterile field
as they say it, uh, uh, it's used
and then it's, uh, thrown away.
Yeah. Gotcha. Give give us an idea of the, the,
the prices involved here.
What's the cost to the surgeon, the patient, the hospital?
How does that all I know there's various reimbursements.
Yeah, there is, is there is.
So, so the principle is that in the United States, which 80%
of our revenue is in the United States.
Mm-hmm. Uh, the procedure is reimbursed
by all major insurance companies
and, uh, uh, Medicare, the government, um, system
for people over 65 in the United States.
And, uh, uh, we bill, we sent an invoice for our device
to the operating theater, to the day surgery.

And we sent an invoice for round about a thousand dollars,
a little bit more than a thousand dollars.
Mm-hmm. And so the, where there are three parties
to the transaction, there's the doctor performing the
surgery, there's the facility that is housing the surgery,
providing infrastructure and the bed and the care,
and us the supplier of the device.
So, um, broadly speaking,
when the submission is made to the, uh, Medicare
and insurance companies, the doctors
in 2026 receive about $540 for their labor.
Uh, and the, um, uh, doc, the, um,
facility receives $2,240,
and of that 2,240, they pay us about a thousand so that
that business, all the parties make, make some money, uh,
and the returns are commensurate with the effort being made.
And, uh, there's a system of making sure that that lines up
with how much, uh,
resources are being applied to the procedure.
Yeah. So, um, that's, that's how we, um, you know,
so our job is to deliver land that in the hand
for a doctor at a good gross margin.
We report our gross margins at, around in the United States,
at around about, uh, just over 70% gross margin.
So, uh, we're proud of our gross margin
and the fact, as you mentioned at the start,
we're closing in on, uh, uh,
EBITDA positive over this next, uh, few months.

Yep. Um, so, so prior to you guys coming along, what was,
and I know you've mentioned eyedrops,
but I touched on some of these other sort of more
invasive kind of pro processes, I guess,
but more, more extreme cases.
So when, when the surgeon sort of looks at, you know,
the job at hand, they've got a few choices here.
So, um, tell us a little bit about the, the, the,
the market you're trying to capture, or,
or steal might be the better word here.
What, what are you competing against?
So, so we're, we compete with, um,
uh, the glaucoma is a disease
that has various levels of severity.
Um, unchecked, someone
with very high eye pressure has no choice
but to have quite a radical surgery.
Um, and what interventional glaucoma is to try,
and we treat the glaucoma a little earlier with,
with procedures which are less invasive.
Mm. Um, so rather than wait till someone, rather than, uh,
over the last 5, 6, 7, 8 years, the, the,
the doctors are saying, I don't wanna wait
until a patient's been bathed, had drops for 30 years,
and then we're gonna drill a hole in their
eye, relieve the pressure.
Yeah. We are gonna treat it earlier.
And, um, that's what interventional glaucoma is about
with surgery, which is not so invasive.

Yeah. And so, uh, we, um, there are,
broadly speaking, a doctor is faced with a choice to, he,
he could, he or she could implant a stent.
Mm-hmm. The doctor could, uh, also tear tissue, uh,
by saying, well, let's just open things up.
We try and separate ourselves from other devices by saying,
our surgery, uh, doesn't require any tissue tearing
and doesn't require any stent left behind.
And so it's a natural, um, it's a natural, uh, uh,
way to get the system the, to clear the system that's,
and without having to tear tissue, we, uh,
there is less opportunity for bleeding.
Mm. And so a doctor who is giving somebody a new lens,
and it doesn't have to be someone who's getting a new lens
to get this treatment, but in a lot of cases it is.
The doctor doesn't want at the end of that,
to have an eye that's all bloody.
And for the patient to look in the mirror
and see a bloody eye, they think, well,
that wasn't so much fun.
Yeah. Blood is the enemy of the, the doctor.
And so we'd like to try
and think that, um, our device
minimizes the opportunity for, uh, bleeding. Yeah. Mm-hmm.
And I suppose to the insurers
and well, every, all stakeholders, like the idea of, uh, a,
a more, um, an earlier intervention, um, for all the,
you know, common sense medical reasons,

but also for the cost reason, I suppose.

Yeah. I, I think, um, well, it's like all diseases.

This is an interesting topic.

We, uh, treating diseases earlier, um, does

all diseases we see all the time, let's treat things easier.

Whether it's bulk bowel cancer or breast cancer

or prostate cancer, we, we treat diseases earlier, uh,

in order to prevent downstream cost

and the cost of the health systems now.

Yeah. I, I have a more micro view of that.

I think that is all true. Mm. But it is our job.

We are not, uh, our shareholders don't want us

to change the world and the me health medical system,

they want us to make, have sales growth and profit.

So I just focus on the little things. Yes.

Sure. Sure. Um, and,

and tell us a bit about the, the training that's involved.

So a surgeon becomes aware of, of eye tracking

and goes, geez, I wouldn't mind giving that a go.

How, how quick can they sort of start using this device?

So, um, that's more or less what happens.

We, we, they become aware and we try and book a time, and,

and our sales reps are skilled enough to be able

to, uh, explain it.

But first of all, um, a lot of these doctors, uh,

those doctors who are skilled in cataract surgery

or have perhaps tried other devices,

um, all are capable.

They all understand some principles.

And so, with a bit of training specific to our product,
you know, we'd like to think that five cases in,
if someone's committed, that they become pretty,
um, uh, pretty good at it.
And, and, and we, uh, you know, try
and keep them motivated to, um,
if they need retraining, we can give them retraining.
Um, but these surgeons, eye surgeons,
ophthalmic surgeons are, are pretty skilled people.
Yeah. Working in a very, very small face. Yeah.
A small place. And, um, uh, you know, they're very skilled.
Uh, the ones I see, you know,
they have very nimble hands. Yeah.
I mean, I, I, I'd like to think that's true
of all surgeons, or at least the ones
that have got a knife over me, at least, anyway. Yeah,
That's right. That's
right. Um, Tom, one of the, one of the, um, themes
that comes up again
and again when we're talking to people in,
in your space in medical technology is we, we have
what you might call the scientific backing.
You have the evidence, you have all of the stuff
that you can present to the customer, the surgeon.
Yeah. And, and,
and that's a huge hurdle to sort of build up that, that,
that body of evidence.
But then one, one, as I say, one of the themes

that just regularly comes up for us is
that then you have this sort of this cultural challenge, uh,
or, you know, there's an inertia, like in any kind of field,
you know, it's like, I've been an ophthalmology, uh, uh,
an eye surgeon for,
I'm not gonna try and pronounce the word.
I've been an eye surgeon for 20 years.
I've used this, this is what I know.
I'm sticking with that kind of stuff.
And you have this sort of social barrier to get past.
Now, you guys have been in market for a while now,
and it, it, it seems at least if you just look at the sales
figures, that, that there is some momentum
building in terms of awareness.
But can you speak to that?
Has, has that been a bit of a challenge?
And, and do you feel like you're getting to the stage
where the more and more surgeons use it, the more
and more reference sites, so you'll be able to, to,
to newer surgeons go, well, go speak
to Linda or Barry over there.
They're using it, they'll tell you what it's about.
There's, there's no doubt that doctors listen to peers,
their peers more than they listen to sales reps.
And that's healthy and good. Yep.
So we have a very strong, um, medical advisory board with
important doctors who are able to speak on our behalf.
And we, they will at a, you know, at a big industry meeting
with an associated, uh, trade show, uh,

industry show on the side will, uh, say, look,
this is the device I'm using,
these are the results I'm getting.
And, uh, it, it, it's really good. Yeah.
Uh, and that's, that sort of thing drives people
to our booth to try it.
Yeah. Um, now sometimes
all pe eye surgeons are no different to any other people in
that change.
Not everybody likes change.
Um, but, you know, they, some may never pick us up.
But, you know, eventually, um, once upon a time, it was,
as I understand before my time, once upon a time, uh,
the idea of implanting, uh, uh,
an intraocular lens in someone's eye,
an artificial lens was considered absolutely crazy.
That was just in the eighties. Yeah.
Now, now, um, you know,
it's the world's most common operation.
So eventually these things, they do take time.
The other, uh, yeah.
And, and the buildup of medical evidence, as you said,
more peer review papers, more, um, data,
more doctor speaking.
And that's the reason we, we fairly recently,
we invest pretty heavily in clinical data.
'cause you can't stop. And we recently put out an
announcement about our iTrack registry where doctors,

there's about 20 sites, 20 doctors across 20 sites

are contributing vol, uh, contributing data,

real life data into a registry.

And so that the controlled environment of that registry, um,

collects the records

and enables us to release papers, um, from

that peer review papers.

And our first paper was just released from that,

like last week or the week before last week.

Right. And where, so there was more evidence,

the American Journal of Ophthalmology, uh, posted a, a,

a paper, uh, which describes, I can't think,

I can't remember how many eyes,

but maybe about a hundred eyes of people

that had had the treatment and the results were good. Yeah.

Yeah. Uh, amazing.

So, so, um, do you have an estimate in terms of how much,

um, I mean, the market itself is growing, so with

that, that's the first thing Yeah.

To sort of note, but also within the,

within the existing market, what is the potential

for, for disruption?

Yeah. Would you say twenty ten five?

Well, how, how many, what percentage

of surgeons are currently using

Using? So, so

at the moment, we measure it in terms of, um,

there's some industry estimates as to the market size.

And we, uh, have a pretty good feeling about the size of the market in the United States.

Outside the United, United States, it's a bit hard.

But inside the United States, we estimate that we have

just three to 4% market share.

And so we,

and once again, I don't care about three to 4% market share.

The message isn't, oh, they're tiny.

They've got a, a, a, a, a poor market share.

The message is, wow.

So that means if got it to 7%, you'd have revenues of

just do the calculation, 60 million Australian dollars,

and you go, that's the message I want, uh,

investors to think about.

That we have, uh, uh, a consistent growth.

Uh, you mentioned at the start, we've we're,

we've put out some data.

It's 40% compound annual growth rate in the United States.

Uh, and that, that if that continues, then we have a,

and we have no reason to doubt it, that sort of, uh,

revenue growth is available

to us from the market that we're in.

Yep. Uh, you, you reminded me then of that old, uh,

shoe salesman bit.

You know, it's like you, two of them go to Africa and,

and one of them comes back to the head office

and says, oh, it's a, it's, there's no point going there.

No one wears shoes. The other one comes back

and goes, this is brilliant.

No one wears shoes. Right. That's right.

It depends how you wanna look at it.

And I, I, I sort of, I'm with you.

I have, I err on the ladder interpretation of it. Um, yeah.

Uh, tell me, tell me a bit about the

manufacturing, uh, of this as well.

So this isn't something you just bang up in any old

workshop, so, so in terms of, you know,

where's that located?

What's the capacity, uh, you know, how, how, how anything

that you think is relevant on that front?

Yeah, so we are manufacturing, uh, our

catheter final assembly is being conducted in Fremont,

in the San Francisco Bay area.

Mm-hmm. But we do a, uh, part of it in this video, there was

that blue and white handpiece.

That plastic handpiece is molded

and made in New Zealand, actually on the south island

of New Zealand, where we have a

subsidiary there doing that work.

Yep. Uh, there's a, uh, a very clever

workforce on the south island.

Uh, we also have a little bit of capacity here in Adelaide

for making catheters and special batches.

Mm-hmm. Um, but the main, uh, catheter assembly

and file assembly and catheter production is, is in Fremont.

Uh, as I said, that catheter has

three parts to it.

A night in old wire inside a 200 micron, which is two human hair, thick catheter,

and a fiber optic that runs down it.

Yeah. And that, uh, is covered in a lubricious coating

to enable it to slide through the structures.

Mm-hmm. So we have, um, pe I think we quoted

that, uh, we've conducted, I mean, globally,

we've done about 180,000 procedures with the device mm-hmm.

Uh, over the years. And, uh, given, you know, it's

around about our run rate at the moment's,

about 25,000 units a year.

Mm-hmm. And, uh, we have capacity for, uh,

for a hundred thousand units Oh, wow.

In, um, in Fremont. Yeah.

Got it. Gotcha. Gotcha.

Um, I changed gears a little bit here.

I mean, you, you mentioned us is is the dominant, um,

a market, but, um, China's on the radar.

I, I see. And yeah. And obviously a, a, a ve well, it,

there's two things with China.

It always strikes me regardless of the company is one,

the market is just absolutely phenomenal, uh, in terms

of it, its size and it, and its potential, but it's,

but it's also got its own unique sort of mix of challenges.

Yeah. Um, how do you, how do you think about that?

It's, it's certainly not something you wanna avoid,

given the potential upside, but,

but I guess you gotta tread carefully.

How, how are you guys going about it?

Yeah. Well, you do have to tread carefully.

Um, we, uh, have, we believe in the Chinese market,

and we've spent time

and effort in getting that device

that we saw in the video approved.

Um, we have had, uh, the previous model

of the device being sold in China, uh, with some success.

And like our market share, we,

I think we published about a million dollars of sales

for the 12 months, uh, to 31 December.

Yeah. Uh, in China.

So it's a bit like our market share in the United States.

Mm-hmm. If it was 3 million, we'd be so excited,

because that's 2 million more than what we're doing now.

Yeah. So we are just treading carefully and making, uh, and,

and getting our advice into the hands of doctors.

Um, we give guidance, uh,

and I explicitly exclude revenue guidance for China

because it is so unpredictable.

And there is also

because we deliver from the United States to China,

sometimes we can get in trouble with tariff, uh, tit

for tat between US and China.

So it can be a bit uncertain.

But that aside, we believe in the long term,

and we are, you use the word trend carefully,

and I'm gonna use that, uh, again

and again from now on. It's a good term.

Yep, yep, yep. The idea of interventional glaucoma and all the patients

and the population in China, the number that have glaucoma,

the need for cataract surgery,

all those dynamics are very, very strong.

Yeah. Yeah. Um, uh, what else was I gonna ask?

Well, actually, well, I was gonna ask you a little bit about

the, the, the sales model.

Um, yep. Because the, you know, there's,

there's usually the, the one

that we encounter is you either license it, which is nice

and easy and capital light,

but you give up a bunch of margin

or you go direct, which you get all the margin,

and then you've, but, but you know,

you've got costs associated with that.

Um, uh, I know a lot of people will know this,

but just for the sake of sort of, of covering all,

all the bases here, can you tell us a bit

about how, how you guys do it? Yeah.

So, so we, in the major markets we have, which are Germany

and the United States, we have a direct sales model.

Um, the principle that we observe is

that if you can't sell your own product in Germany

and the United States, well then you don't have a good

enough product, I guess is the principle.

Makes sense. We do use distributors in other markets. Yep.

Uh, and we, and our sales outside, there's markets are,

you know, they're meaningful to

us 'cause we're a little company.

Yeah. But it certainly is driven by the United States. Yeah.

And, um, I get, um, we,

having your own Salesforce is ex is, um,

expensive, no doubt about it.

Um, but you get to control it.

Uh, I get the text message over the weekend from our leading

sales guy, uh, leader

of our sales in the United States saying, this is

how many we're gonna sell in the month of every time.

And there's this problem and that problem, and this upside

and this downside, all that sort of stuff.

If you don't get that communication,

and I say love from Boston Scientific or AbbVie

or, or one of those big companies that people, um,

the only good part about that is you get

to make an A SX release.

We have now put our, uh, product in the hands

of big company X, YZ in, in America,

and says, oh, that's exciting.

And then a year later there are no sars. Right.

So, uh, we, we are very much controlling our own destiny,

and that's why our journey to EBITDA positive with

that direct sales model is important

because we think we have a very,

very valuable asset with that team.

Yep. That sales channel in the United States.

Well, actually, this, this might be a nice segue into

to some of the questions that we've got.

I got some really good ones here from, from Mike.

He, he makes the point

that you've got a really productive sales team

in the US Yeah.

Um, and we've seen those costs per sales rep

increasing there.

So they, they, they're doing a good job

and seem to be getting better at it. Revenue,

Revenue per sales rep increasing,

Sorry. So revenue. Yes.

Thank you. Yeah, rev.

Well, that's actually worth teasing apart a bit

and I, well, let me, I'll finish the question.

He says, as the company becomes profitable,

what potential do you see

to invest more in expanding the US market penetration?

Yeah. Is there an end game you have in sight

for the size of the US team?

So, so, um, I go back to our 3%, 5%,

6%, 7%.

Uh, that's, uh,

and we would love, I I, we have

to make a profit because people on the Australian stock

market wanna see a profit.

And when in our, um, quarterly, uh, result that we put out,

uh, the first week of February,

we highlighted a very healthy, um, sales rep,

a revenue per sales rep, which much I do it, our competitors see these documents and they act upon them.

Um, some of them tell me, gee, that's very healthy, Tom

and others, you know, that they have a lot of information.

But we do that for the benefit of the shareholders.

And a key driver, as I wrote in their last release,

a key driver of our bottom line operating result is

that revenue per rep.

Yeah. So we are telling the stock market,

telling our investors that while that stays up high,

we can expect good bottom line or improving bottom line.

Yeah. Now, is there an end game?

Um, I don't know what it is. Yeah.

I, I think, I think we want to get double that, you know,

we think that sales growth

that we're achieving can be continued to be achieved

and that within an investment profile,

investing in our stock in order to ca you know, you know,

I I buy a lot of shares myself 'cause I believe it.

And that's the message we're trying to send.

Yeah. Um, well, I mean, it, it hasn't gone unremarked.

I mean, thi this is always, well, not, maybe not always,

but I certainly, I think a, a big cohort of, of,

of our members really pay attention to a, a company

that has made the big investments

that's got the product in market

that's seeing the traction of that market.

And here's the key thing is, is have a, has a bit

of flex in the cost space

and the maths, as I'm sure you know, Tommy just is, is wonderful because Yeah.

You, you get a little bit of, you know, you sustain a bit

of momentum, uh, at the, at the revenue line,

but the profit just explodes as you go past

that break even point.

Yeah. Now, costs never stay flat

and they shouldn't stay flat, you know, and

because fact success, if you sort of say,

what does Nova look like in 10 years time?

I hope your cost space is a lot bigger. 'cause it, it, yeah.

That's suggests that everything's going well. So we

Gotta be talking, we gotta be talking

in percentages, don't we?

Some even are divided by sales something and,

and an annual growth of sales is, that's something exciting.

Yeah. Yeah. Most people want double more than double

digit growth for it to be exciting.

Uh, and so, you know, I'm just this, you know,

we are just the same.

Yep. Yep. Well, well let, let me, let me put in, um, let

advocate for something, uh, we like exciting too.

Um, but, but there is also something to be said for

resilience, robustness and, and, and all the rest of it.

Um, I suppose you've actually touched on this by sort

of saying that, you know, the mark, you, you,

there's an awareness that the market wants to see, uh,

profitability that that's there.

Yeah. So I guess the question is, in,

in a different world where capital was very freely available
and very cheap, and the market was more, uh,
giving you a bit more permission to, to, to delay
or to push back those inevitable cash flows,
do you think you could go harder?
I, i, are you being hamstrung?
I often, I often say, um, to that question that we are
absolutely, we are not exploiting the market potential.
Right. Um, we are, um, focused on the resources we have
and the, uh, carefully making our way to profitability
because, uh, we formed a view
after a lot of, you know, feedback, I suppose, as well as,
uh, that, that that's what the stock market wants.
Hmm. Now that, that's not the case in all other stock
markets around the world
And or at all other times, I, I remember not long ago,
no one cared about profit. Yeah.
Yeah. So, so we, that, that's where we are today. Yep.
Uh, try to, um, you know, have that break even cash flow,
self-sustaining growth that is acceptable and Yep.
Uh, I'm, we, we believe that we'll be rewarded. Um, yeah.
Uh, and you know,
because it's, that that's where we are. Yeah. Yeah.
Yep. I mean, again, I'm for the sake of balance,
I suppose there is, there are, um, I I,
I point this out mainly to, to myself
and other investors, is, is that sometimes a,
a two myopic focus can, can cause you, um, a a bit
of a disservice, for example, as a hypothetical situation,

um, in, in the, with a focus to sort

of generate positive cash flows

and not prosecute as hard as you could.

It gives a little bit of a gap for,

would be competitors sort of come in, maybe one

that's US space and shareholders don't care about profit.

I I, is that a risk, or,

or do you feel as though there's a bit of, bit of daylight

between you and the, and the nearest competitor

that can afford to? Uh,

Our, our, our, um, we talk about, as I said about

that text message over the weekend from our sales letter,

he referenced activity by our competitors.

So we worry about it every day. Mm-hmm.

Um, but, and,

and we believe that we,

the opportunity could be exploited faster if we, um, but,

but we are choosing to, um, make that balanced investment

to develop the internal resilience

or the financial resilience so that we can cope.

So that we can cope.

Um, and you know, I, I look at,

I look at, um, some companies, uh,

large companies in the, in the space,

and not every company,

there are companies in our space that are losing money.

Absolutely. Yeah. And have, um, uh, one

of the biggest companies is Cloud

Plus, it's never made a profit.

Yeah. But, uh, there are also space,

there are also large companies where it's EBITDA positive,

EBITDA positive also in that ophthalmic industry.

Yeah. And they have good valuations too. Yeah. Mm-hmm.

Nice. I I, I'll gonna fire through some questions.

'cause otherwise I'm gonna, I'm gonna burn

through our time here without getting to them all.

Um, another one from Mike.

What challenges does Irak face in gaining public

reimbursement, for example, in Australia?

I understand it is approved by the TGA,

but as yet is not reimbursed, if that's correct.

What's the status of the reimburse reimbursement

application if one has been made?

Well, I think, um, I think that's exactly the, uh,

resource allocation question that we deal with every day.

Yeah. So there is an amount of money we need to do, uh,

to show to the reimbursement authorities that, so basic,

broadly speaking, we've shown data

to the American government,

and the American government said, yeah, that's cool.

We show it to the Australian government.

They say, no, that's not cool. We need more.

And so we then say, well, is it it worth our effort

to spend the money on the Australian market,

or should we put another rep up in the Pacific Northwest

or in New York City or in, um, or in, uh, uh, North Carolina

or in Florida where we get immediate return on those funds?

Yeah. No, those are the decisions that we have to make
be when we are progressing sales growth
and EBITDA positive as a strategy.
Yeah. We sometimes have to leave
behind the longer term things that the, and it,
and it's a bit sad that we,
we don't have any sales in Australia,
but, um, it's not quite zero, it's close to zero though.
Mm-hmm. Um, but that's the, that's the, um, price we paid,
I guess, for our laser focus on, on growth
and EBITDA positive.
Yep. Yep. And us
and China are much larger,
larger markets anyway, so you Yeah.
It makes, makes a lot of sense.
I I got one from Kearney here, uh, Tom, um,
is there a particular US ophthalmology practice structure
that is incentivized to use, I track as a consequence of
how the government reimburses for, uh, canal Canaloplasty?
Canaloplasty, canaloplasty? It's a bit of a tongue twister.
Uh, and, and so how, and,
and if so, how does that influence how I track is marketed?
No, so the, I described the reimbursement structure
earlier, um,
and that applies to all facilities that use iTrack.
Right. Uh, and so it doesn't, it also, yeah,
it applies to all facilities.
So there isn't one particular, um, facility

or a group of facilities that, um, do it.

There are places like, uh,

big private hospital groups that require you

to convince them, uh, and Kaiser Permanente is one.

Um, people may have heard big, big self

running hospital group.

Mm. And you need to convince some CMO

of Kaiser Permanente that to have us on their list.

Yeah. Uh, and we, we are on various lists, including Kaiser.

Um, and you then have to,

but you still have to convince individual doctors within

that structure mm-hmm.

Um, to use the device.

So our marketing effort is about peer-to-peer selling,

collecting data, peer-to-peer selling, um,

making our presence felt, uh, develop at all with a view

to develop leads to feed those reps.

So off they go in hand-to-hand combat on the streets, um,

getting orders for us.

Yep. Nice. Nice.

Um, another one, uh, from Kearney, the, uh,

he's asking about the, uh, via 360

by streamlined surgical systems.

Um, you've got approval in Feb last year, uh,

and he says, in many ways a big validation of iTrack

and its implant free approach.

What's your understanding of V 360

and how it competes with iTrack?

So we, we had some public, um, information in there about how, um, uh,

all the devices, uh, compete.

Um, we note about, um, that,

that, and our device has certain features,

and those features are the light,

the 360 degrees navigation.

It has an indication for, um, treating glaucoma and where,

and, and it doesn't tear tissue now including via, including

V 360 and other devices that I have on that list.

We still have competitive advantage over all of those.

So calling out one device is only just sort of,

you know, whatever.

We, um, it's a competitive, there,

there is competition and we watch it.

Mm-hmm. Um, but the, the, um,

and, and we describe the Air 360,

which doesn't actually have an

indication for treating glaucoma.

Yep. Yeah. Uh, I've got two more here for you.

Um, from Bradbury, we,

we touched on the production capacity, um, so I'll skip

that part, but he says, I assume it's not a quick process

to bring extra capacity online.

When do you see the need to increase capacity,

and what do you think the capital outlay looks like

to expand those facilities? Yeah,

So, so let's talk about capital outlay

and say there is, is almost none.

Okay. So the facilities in place, uh,

the clean rooms are in place,

and if I go to our place in Fremont, there is space, right?

Uh, we buy a microscope for a couple of grand.

It is about bringing on the people.

Uh, and, uh, we have a, the reason, uh,

the reason that iTrack is in Fremont is it is a, uh,

medical technology hub.

There is a community of people with the right skills.

Mm-hmm. Uh, and so we can recruit

and train somebody over a couple of months, month even, um,

in order to, um, get 'em up to date.

So the, uh,

and we are constantly forecasting our results, matching that

with our labor, uh, capability, given the nu number

of hours it takes to build

things and all that sort of stuff.

Um, but it's not, we don't really have any impediment

apart from work, pure work

and management to, um, uh,

uh, you know, to grow our production capacity.

Yep. Uh, one also on the, uh, the,

the current capital structure.

So we've got a good chunk of cash there in, in the bank,

you know, 2.6 million or so.

And, um, I know this becomes a less pointed question as you,

as you've crossed that sort of threshold.

Yeah, yeah. And, and I,

I do ask this question very cognizant of the fact

that the answer does very much depend on,
on market conditions.
If the share price 10 x from here, you might,
you might change how you answer this,
but for the, for the foreseeable future is, do you,
do you feel as though, for the sake, just for the sake of,
uh, a, a risk assessment,
let's say capital markets just shut up, you know,
investors aren't interested, banks aren't interested, um,
you got enough there to sort of see yourself through to,
to viability and, you know, keep operating?
Uh, yeah. I mean, we highlight in our, uh,
the stock exchange, uh, mandates a form a formula,
and we, uh, have the formula, uh, that says, um,
uh, that they say, if,
if you don't reach this rest threshold,
tell me when, raise capital.
So we haven't lose the threshold. Yeah.
So, um, we, uh, are working very hard at,
um, that improved cash flow.
We've informed our shareholders about how that looks.
Mm-hmm. Uh, and every day, uh, we,
we focus on getting the money, sending out catheters.
I, I get sending out catheters
and getting cash in from our customers.
It's, uh, a very simple in my head.
Now I can, I can measure what we got in today
and what we delivered out.

So we're gonna get that later this week

or later this month. So,

Yeah. Nice. Um,

It's coming formulaic.

Yeah. Yeah. Oh,

so pretty quick cash collection cycle then.

Yeah. We had a good accounts receivable.

Yes. Yeah. Yeah. Great.

Um, uh, the last one I've got here, and,

and you, you've touched on this,

but I'll put it to you in case there's anything left, left

to say, uh, uh, Bradbury's sort of making the point that,

you know, outside of Germany and China, uh, you know,

there are other opportunities

and you said you are in, in, in other markets.

Yeah. And you've, you've said that, look,

let's just focus on the, we've made the investment,

we've got the opportunity, that's

where the low hanging fruit is.

Um, but are there any substantial markets out there

that you might sort of, uh,

I think there's a higher priority going forward.

Historically, the market that is, uh, possible for us is,

um, we re uh, is South Korea is a good one.

Oh, yeah. South Korea is one we like.

Uh, we're not selling here.

We'd like to, and, um, the UK continues to,

I mean, we are currently selling in the uk

and it is doing very well.

So, um, that, that's a good market for us.

The, the markets we like in that rest of the world are,

they're very, there aren't that many, uh, but Poland

and the uk, uh, and Canada, Canada is not bad either,

but Poland and the UK have been really good.

Mm. So, um, and it, it is a, it is a, uh,

a we don't bother with France

because we see the reimbursement system

as being not conducive.

It's a bit like Australia.

Um, but it's, they're also, we have good people, uh,

good partners in those in UK and Poland as well. Yeah.

Um, move a little bit away from, from iTrack,

but, uh, question I've got here is, um,

while the market's currently valuing no variety is

glaucoma business, there's a wholly owned subsidiary

Alpha Re Yeah.

Uh, working on laser therapy, uh,

for age-related macular degeneration.

Yeah. What, what, what can you tell us about that?

It's just, I guess simmering away in the background is

a bit of extra optionality.

Well, there is optionality there.

Our investment in there has been very, very limited as we

as once again focus on cashflow positive and, uh,

and growth within the glaucoma business.

Mm-hmm. We have a very unique technology there with

that is a very, very short pulse laser that gently, well, for one of a better word, tickles the retina.

And in doing so, uh, rejuvenates retinal cells mm-hmm.

So for retinal disease, uh,

it has been shown in a large clinical study, um,

back in 2019 to have outstanding, interesting results.

It does require more money.

And when we save more money, you know,

more money than the money we have

in our bank account at the moment.

Mm-hmm. But it does have registrations.

Uh, it is a different market to glaucoma,

so we can't give it to our existing sales channel.

And we, so we, we don't yet, yet have the, um,

wherewithal the internal resources to, uh, get

that product into the hands e exploit the existing res uh,

registrations we have.

Mm-hmm. But, um, so at the moment,

our position is we would enjoy a partner

to help us take equity in our ette,

not in the parent company equity in our ette, in order to

exploit that opportunity.

But broadly speaking, we see, uh,

no variety has potential between to be

the tissue s spear tissue sparing non, um,

uh, uh, non-drug drug free tissue sparing,

uh, ophthalmic treatment technologies.

Mm. So, uh, and there is, I I, I think

that's an appealing concept.

And, and when shareholders buy,

or when investors buy our shares, they
get themselves optionality of that tab.
Yep. Um, getting close to the end of it, I'll, I'll,
I'll let you go in a minute, Tom.
Um, so the, the iTrack advance is not the first generation
and, and presumably won't be the last.
And this is always, there's always
that natural tension, isn't there?
It's sort of like you could just halt all r and d
and all long-term investment efforts speaking of cashflow.
Right. And maybe the market would like that, of course,
for any of us who are a bit longer term focused, well,
you all of a sudden you're on borrowed time.
So there's no right or wrong answer to this.
It is, it is a subjective one, but,
but how do you as the CEO wrestle with that tension? So,
You know, yeah. Um,
well, it's exactly as you described, and,
but we are aware that we need
to make incremental improvements to our device in order
for it to remain relevant
and, uh, both for competitive reasons and
because we think it's a platform that has potential
to do lots of things.
Yeah. Uh, and so we do make those investments
and, uh, as a board, as a, you know, we,
we say we just have to, you know, there,
there's a minimum in order for us to continue to, we,

we just, people like the growth

and they'd love to see cash flow positive,

but if you said we're stopping RD,

they'd say, oh, no, you can't do that.

Yes. So we might ask that question, we just do. Yeah,

Yeah.

Yeah. I, I, I, uh, I love that.

I honestly, I, I do think as a general rule, um, uh,

a SX company should tell investors

to take a hike more often.

You know, we we're, we're a demanding bunch.

And, and you're right. You know, the, and, and,

and what the, the market decides it wants will change.

You know, it's, it's a bit bipolar.

It changes a lot faster than you can actually

make strategy and change. Yeah. Yeah.

And, and so you, I look, this, my, my,

my 2 cents is you shouldn't, you know, you, you are on the

inside, you know the opportunity, you know the product,

you know what's going to make sense.

And, and, and I've just, I've seen it a lot in the past

where it's sort of like in trying to keep a, a, a cohort

of investors happy, who will never be happy, you,

you actually let things slip through your fingers.

So that, that my urging is just stay focused

because, uh, you, you've got a clear

Yeah. That's, that's, that's the

role of managers.

We have to make choices and, uh,

and investors expect us to make choices.

They're not just listen to them blindly.

Yep. Yep. We don't know what we, or, or when I say we,

and I think for a large chunk of the market,

it's just make the share price go up.

And, and the reality is, the certain techniques that, uh,

work pretty well in the short term tend to be the ones

that undercut you in the long term.

So, and I also,

You know, the, the, the issue of share price going up,

I mean, I, my mental health should not be so share

Price. Yeah. Yeah.

It's a madness.

Look, Tom, honestly, I honestly think too, you,

you do get the shareholders you deserve.

And if, if I can put in a, an ad for us, us, I, I think

as we're a broad church, different,

different people do different things,

but, uh, uh, in the whole, I I think you've got people

who are, who are looking to partner with a company

that has a long-term vision

and opportunity in this, focused on that.

And also, I would say, aren't the kind of people to,

you know, have a conniption if the share price goes down,

volatility is our friend.

We like it. Yeah. So you've, you've, uh, you've,

you've got a lot of understanding amongst our IR group.

Um, let, let me, let me, let me wrap it up here.

Um, I'm sure in your position, you gotta speak
to the fundee, the analysts, the investors.
Yeah. Uh, various sort of stakeholders.
What do you reckon it is that most people miss when,
when people are looking at Nova?
I am, I'm sure you often log off a call
and go, bloody hell, everyone's asking me about this,
or No one's asking me about that.
You know, I,
I think, I think our, our American sales channel
is very, very valuable,
and our shareholders see cost,
but they don't see, well, I mean, it is possible.
I shouldn't say they do,
but it is possible to let get carried away with the cost
of a sales channel rather than see it as such a major asset
that ultimately is what is adding value to our company.
Not, um, you know, I mean the pro
as we've decided the profit's important.
Absolutely. Sure. But it's that channel, um, those, uh,
clever people putting our devices in the hands of doctors,
which is what attracts, which I think is
what generates value as well as the product itself.
The, the purity
and the, um, uh, the innovativeness.
That's a word of the product. Yeah.
Yeah. Oh, yeah. I lo I love that point.
It, it, it's, it's a, you know, yet another example of
so much of the value that isn't

as captured in the financial statements.

Yeah. You know, like, it's just, it's, well,

certainly not in the balance sheet in terms of,

if you want to call it an asset Yeah.

The, the quality of the people there.

But the longer I've been at this game,

the more I'm convinced that it is the qualitative stuff

that is the important stuff.

So I'm, I'm, yeah. Interested to hear you emphasize that.

That's, that's really great. Um, I better let you go.

Any, any closing thoughts or,

Or, no, that, that's, uh,

some great questions there, Andrew.

I appreciate your effort and time and, and research.

That's wonderful. Thank you.

Well, thank No, well, thank you.

And as I say, there's been a, a lot of interest, um, for,

for Noray amongst our group.

And look, we, we don't want to bother you too much,

but maybe in another 12 or 18 months we'll reach out again.

Yeah, yeah. For a bit of a follow up.

Okay. Thank you. Awesome. Thank you. Thanks, Tom.

Thanks everyone. Bye.