Nucleus® Hybrid™
L24 Implant System

Ear, Nose, and Throat Devices Panel Meeting
Cochlear Limited
November 8, 2013
Introduction

Christine Menapace, MA
Vice President Clinical, Quality and Regulatory Affairs
Cochlear Americas Corporation
Nucleus® Hybrid™ L24 System Components

Patient Components

- Nucleus Hybrid L24 Implant
- Nucleus 6 Sound Processor
- Remote Assistant Options
- Electric Component
- Acoustic Component

Programming Component

- Custom Sound Fitting Software – Version 4.0
- Intraoperative Remote Assistant (optional use - not shown)
Indications for Use

• The Nucleus® Hybrid L24 Implant System is intended for patients aged 18 years and older who have residual low-frequency hearing sensitivity and bilateral severe to profound high frequency sensorineural hearing loss, and who obtain limited benefit from bilateral hearing aids.

• Typical preoperative hearing of candidates ranges from normal to moderate hearing loss in the low frequencies (thresholds no poorer than 60 dB HL up to and including 500 Hz), with severe to profound hearing loss at frequencies above 1500 Hz (threshold average of 2000, 3000, and 4000 Hz ≥ 75 dB HL).

• The CNC word recognition score will be between 10% and 60%, inclusively, in the ear to be implanted in the preoperative aided condition and in the contralateral ear will be equal to or better than that of the ear to be implanted but not more than 80% correct.
Cochlear Panel Attendees

J. Thomas Roland, Jr., MD
Lead Investigator, New York University Langone Medical Center
Mendik Foundation Chairman, Department of Otolaryngology-Head and Neck Surgery
Professor of Otolaryngology and Neurosurgery
Co-Director, NYU Cochlear Implant Center

Bruce J. Gantz, MD
Principal Investigator, University of Iowa Carver College of Medicine
Head, Department of Otolaryngology—Head and Neck Surgery
Brian F. McCabe Distinguished Chair in Otolaryngology—Head and Neck Surgery
Professor of Otolaryngology and Neurosurgery

René Gifford, PhD
Assistant Professor, Vanderbilt University
Director, Cochlear Implant Program
Associate Director, Pediatric Audiology Services
Vanderbilt Bill Wilkerson Center
Department of Hearing and Speech Sciences

Christine Menapace, MA
Vice President Clinical, Quality and Regulatory Affairs
Cochlear Limited

Aaron J. Parkinson, PhD
Principal Clinical Studies Manager
Cochlear Limited

Sean Bundy
Director, Regulatory Affairs
Cochlear Limited
Additional Cochlear Representatives

Chris Mullin, MS
Director of Consulting Services, Statistician NAMSA

William H. Shapiro, AuD
Director of Audiology, New York University Langone Medical Center

Christopher W. Turner, PhD
Professor, University of Iowa

Kristien Verhoeven, PhD
Medical Device Biologist, Cochlear Limited
## Agenda and Presenters

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<td>J. Thomas Roland, Jr., MD</td>
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Clinical Background and Rationale

René Gifford, PhD
Assistant Professor, Director of Cochlear Implant Program
Director, Cochlear Implant Research Laboratory
Vanderbilt University
An Unmet Need

• High frequency hearing loss ("Ski-slope") loss is common
  – Normal to moderate low frequency hearing loss, but severe to profound sensorineural hearing loss in the high frequencies

• Individuals experience significant hearing difficulty and fail in their social and work environments
  – Poor speech intelligibility, talking on the phone, difficulty in noise
  – Frustration is high
## Current Therapy Options

### Current technologies are inadequate

<table>
<thead>
<tr>
<th>Option</th>
<th>Details</th>
</tr>
</thead>
</table>
| **Amplification Alone**         | • High frequency loss is not effectively addressed  
• Frequency lowering technologies (FLT) are limited  
• Dissatisfaction is high       |
| **Standard Cochlear Implantation** | • Destroys remaining low frequency acoustic hearing  
  – Which improves hearing in noise and aid localization  
  – Electric hearing does not provide these important cues  
• Beyond the scope of current indications |
| **Do Nothing**                  | • Individuals are highly frustrated, having exhausted many options - constant struggle to listen effectively, interact and remain independent |
Physiological Limitations: Cochlear Dead Regions

Cochlear dead regions are prevalent when thresholds \( \geq 70 \text{ dB HL} \) (~60%) Vinay & Moore (2007)

Severe to profound hearing loss associated with OHC and IHC damage
Limits of Amplification in High Frequencies

• Numerous studies have suggested limited benefit for amplification in the presence of high frequency hearing loss
  – Thresholds greater than 60 to 70 dB HL

• Limitations of amplification (beyond dead regions)
  – Difficulty in achieving adequate audibility
  – High presentation levels resulting from high gain
  – Poor spectral resolution in basal cochlea

• Excessive high-frequency gain requires occluding ear molds
  – Rejection of hearing aids due to occlusion effect
  – Open-fit or open-canal fittings are not indicated for profound HF losses

Frequency Lowering Technologies (FLT)

• Over 30 years of research with FLT
  – Multiple variations of FLT

• Little to no benefit (< 10-percentage points) for:
  – Phonemes
  – Consonants
  – Plurals
  – Vowels

• Few reported significance at the group level

• Did not use same measures as CI studies
  – Does not allow for across-technology comparison

Recent Research into Frequency Lowering Technologies

Subjects in Study were Audiometric Candidates for Hybrid
Frequency Lowering Technologies (FLT)

Figure 3

![Graph showing speech material performance with conventional and DFC technologies](image-url)
“There were no statistically significant differences between conventional amplification (CA) and DFC for any of the measures tested.”
There were no statistically significant differences between conventional amplification (CA) and DFC for any of the measures tested.

6-percentage points not significant
Frequency Lowering Technologies (FLT)

Summary of Results:

• No significant benefit for speech understanding in quiet or noise for patients with Hybrid-qualifying audiograms
  • Same metrics used in the Hybrid-L trial
    - CNC and AzBio
• No improvement in subjective benefit with FLT
Cochlear Implantation

Benefits
• CI provides access to high frequencies with preserved spectral contrasts
  – Required for high levels of speech understanding

Limitations
• Fine Structure Cues
  – Rapid fluctuations in sound are not well transmitted by CI
  – Fluctuations are well preserved in LF acoustic hearing
• Current labeling indicates that all residual hearing will be lost.
  → Loss of fine structure in LF acoustic hearing
• Candidates for the Hybrid L24 Implant are not candidates for a traditional cochlear implant.
Benefits of Low Frequency Acoustic Hearing

• Access to low frequency acoustic hearing is associated with better:
  – Localization (Dunn et al., 2010; Gifford et al., submitted)
  – Pitch Recognition (Kang et al., 2009; Wright and Uchanski, 2012)
  – Hearing in Noise (Dunn et al., 2005; Gifford et al., 2007; Dorman et al., 2009)
  – Melody Recognition (Dorman et al., 2009; Gfeller et al., 2006, 2007, 2012; Wright and Uchanski, 2012)
  – Interaural timing cues (Gifford et al., 2013)

• LIMITATION: LF hearing alone is not sufficient for high levels of speech understanding
Electric and Acoustic Stimulation with Hybrid L24

Simulations courtesy of Mario Svirsky, Ph.D. NYU Medical Center
Electric and Acoustic Stimulation with Hybrid L24

Apex

Base

500 1073 1483 2037 2777 3770 5100 6683

Simulations courtesy of Mario Svirsky, Ph.D. NYU Medical Center
Hybrid L24: Viable option for the “in-between” patient

Hybrid L24

Conventional, FLT, & implantable HAs

Cochlear Implantation
Development of the Hybrid L24 Implant

Bruce Gantz, MD
Principal Investigator
University of Iowa
Hybrid History

• 1988: Research into cochlear implantation in severely hearing impaired subjects began

• Early 1990’s: Began to recognize many CI patients perform better than those with amplification

• Based on inadequate treatment options and clear patient need the following questions arose:
  – Can we expand electrical speech processing to more of the hearing impaired population?
  – Is there a downside to implanting those with more residual hearing?
  – What are the advantages of preserving residual auditory function?
Hybrid History

1996
Development Began
(University
Iowa/Cochlear Corp)

1999
IDE Approval
3 Subjects,
(6mm/6 electrode),
Hearing Preserved

2000
Gantz & Turner Report,
3 pts; 6th International
CI Conference,
Miami Florida

PRE AND POST OPERATIVE AUDIOGRAMS (1999)

Patient 1
PRE CNC= 9%
POST CNC=8%
PRE CUNY=38%
POST CUNY=30%

Patient 2
PRE CNC=10%
POST CNC=10%
PRE CUNY=95%
POST CUNY=97%

Patient 3
PRE CNC=15%
POST CNC=20%
PRE CUNY=90%
POST CUNY=92%
Nucleus Hybrid L24 Electrode Array

22 Half-banded electrode contacts

16mm; approx. 250° insertion

Stabilizing handle

Base
HL: 0.40x0.55mm
CA: 0.80x0.80mm

Apex
HL: 0.25x0.35mm
CA: 0.50x0.50mm
How the Hybrid L24 Electrode Works

Hybrid L24

FREQUENCIES THAT ARE AUDIBLE:

- LOW 125
- 250
- 500
- 1000
- 2000
- 4000
- 8000

Sound frequency range

Amplified sound

The cochlea function when stimulated with the Hybrid System

Standard Freedom

Hybrid L24
Hybrid Surgical Technique

- Same basic approach as cochlear implant surgery
- Specific care taken to protect hearing
  - Similar approach to drill-out stapedectomy
  - Diamond burr, slow speed, no suction of perilymph
  - Slow insertion of the array
- Cochleostomy (0.75mm – smaller than CI)
  - Anterior to floor of round window membrane
- Round window
  - Used in European study with good results
Round Window Surgical Approach

• Data are available from outside the US demonstrating that the round window approach is appropriate
  – Results of the study are published; it is important for surgeons to have access to surgical instructions for this alternate approach

• Both approaches are approved for the Nucleus CI422 Cochlear Implant, electrode placement inside the cochlea is similar for both approaches

• Cochlear believes the decision should be based on the surgeon’s judgment regarding the anatomical circumstances for each patient

Pivotal Study Overview

Aaron J. Parkinson, PhD
Principal Clinical Studies Manager
Cochlear Americas
Study Design

- The study was conducted as a multicenter repeated-measures, single-subject design, where each subject served as his or her own control
  - Design appropriate since it accommodates the heterogeneity that characterizes hearing-impaired populations, including cochlear implant recipients
  - This study design has been implemented for many years in cochlear implant clinical trials and research studies
- Blinding or masking procedures were not possible to conceal the presence or absence of a cochlear implant from device recipients and/or clinical investigators
Key Inclusion and Exclusion Criteria

INCLUSION
- 18 years-of-age or older at the time of implantation
- Monosyllabic word scores between 10% and 60% in ear to be implanted (worse ear)
- Word scores equal to or better than ear to be implanted, but no better than 80%, in the better ear

EXCLUSION
- Duration of severe to profound high-frequency hearing loss greater than 30 years
- Congenital hearing loss (for this study, onset prior to 2 years of age)
Hearing Aid Fitting Guidelines

• All hearing aids were **verified** to be appropriately fit based on the widely accepted **NAL** prescriptive rule, consistent with ASHA practice policy.

• A majority, 49/50, were hearing aid users at study entry¹ with an average of 18 years use.

• In the event that amplification was not used, a **minimum** 14-day hearing aid trial was required prior to assessing candidacy.

**Make and model was documented for each ear¹**

• 92% of cases used current digital technology.

• 31% had tried ipsilateral Frequency Lowering Technology (FLT) prior to enrollment in the Hybrid study (all digital technology).

¹ This information was not provided to FDA in original PMA submission.
Test Conditions

5 pre and post listening conditions tested

Implant Ear

Acoustic Alone

Electric Alone

Hybrid Mode (Study Endpoint)

Both Ears (Everyday Use)

Bimodal Mode

Combined Mode
Evaluation Intervals

Preoperative: All Measures

Postactivation: Initial activation, 3, 6, 12 months and semiannually thereafter

Endpoint: 6 Months postactivation
Study Measures

**PRIMARY**

- CNC Monosyllabic Word Recognition Test
- AzBio Sentence Test in Noise (+5 dB SNR)
Efficacy Endpoints - Implant Ear

**Co-Primary**

Use of the Nucleus® Hybrid™ L24 Implant System will improve speech perception, as measured at the 6-month endpoint by:

- CNC Monosyllabic Word Recognition
- AzBio Sentences in Noise

**Secondary**

Most subjects (> 75%) will score equal to or better at 6 months than the preoperative unilateral condition:

- CNC Monosyllabic Word
- CNC Phoneme Recognition
- AzBio Sentences in Noise
Safety Measures

Adverse Events (AEs)

- Any surgical and/or device related event
- Reported as the number and proportion of individuals

Hearing Sensitivity

- Subjects’ levels examined to assess any changes and to characterize impact on low frequency hearing sensitivity
Speech, Spatial, & Qualities of Hearing (SSQ) Questionnaire

- A Self-Assessment Questionnaire
  - Validated metric
  - Commonly used in CI and HA research
- Measures listening ability in a large number of listening situations
- Assesses 3 overall domains:
  1. Speech hearing in quiet and noise
  2. Spatial hearing - where sounds are coming from, and from what direction and distance
  3. Qualities of hearing - music, naturalness of speech & music, sound segregation, ease of listening/listening effort,
- 49 questions, self administered
Device Use Questionnaire (DUQ)

• An “in-house” designed device usability metric, complementary to the SSQ
  – Adapted from questionnaire previously used in FDA approved implantable middle ear studies

• Administered to determine subjective preferences with regards to device use in various listening environments

• It was administered preoperatively, 6 months postactivation, and 12 months postactivation
  – The preoperative questionnaire contained 93 questions
  – The postoperative questionnaire contained 95 questions
  – The majority of the questions were multiple choice
## Evaluation Matrix

<table>
<thead>
<tr>
<th>Evaluation Item</th>
<th>Baseline Evaluation</th>
<th>Initial Activation</th>
<th>3 Months</th>
<th>6 Months</th>
<th>12 Months‡</th>
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</thead>
<tbody>
<tr>
<td>Consent Medical &amp; Hearing History</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hearing Aid Verification</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unaided Hearing Thresholds &amp; Tympanometry</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Aided Audiometric Thresholds</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CNC test in quiet</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>AzBio sentences-in-noise test</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adaptive SRT in noise</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>UW-CAMP music perception</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Questionnaires (SSQ, DUQ, MBQ)</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Psychophysical Ts, Cs &amp; electrical impedance</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adverse Events</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

¶ In the event that a change in hearing > 10 dB at two or more frequencies occurred since previous visit.

‡Subjects were followed up semiannually thereafter
## Study Sites and Principal Investigators

<table>
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<tr>
<th>Study Site</th>
<th>Principal Investigator</th>
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</thead>
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<tr>
<td>NYU</td>
<td>J. Thomas Roland, M.D. (Lead)</td>
</tr>
<tr>
<td>University of Iowa</td>
<td>Bruce J. Gantz, M.D.</td>
</tr>
<tr>
<td>Center for Hearing &amp; Balance</td>
<td>Jacques Herzog, M.D.</td>
</tr>
<tr>
<td>Hearts for Hearing</td>
<td>R. Stanley Baker, M.D.</td>
</tr>
<tr>
<td>Mayo Clinic, Rochester</td>
<td>Colin Driscoll, M.D.</td>
</tr>
<tr>
<td>Midwest Ear Institute</td>
<td>Charles Luetje, M.D.</td>
</tr>
<tr>
<td>Northwestern University</td>
<td>Andrew Fishman, M.D.</td>
</tr>
<tr>
<td>Ohio State University</td>
<td>Brad Welling, M.D., Ph.D.</td>
</tr>
<tr>
<td>Rocky Mtn. Ear Center</td>
<td>David Kelsall, M.D.</td>
</tr>
<tr>
<td>University of Cincinnati</td>
<td>Ravi Samy, M.D.</td>
</tr>
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</table>
Enrollment & Accountability of PMA Cohort

- One subject reimplanted with a cochlear implant; did not complete 6 month test interval.
- Two subjects withdrew prior to 12 month test interval due to medical conditions unrelated to the device or procedure.
- Two subjects reimplanted with a cochlear implant; did not complete 12 month test interval.

Enrolled & Implanted: 50 subjects at 10 sites

1 month Initial Activation: 50 subjects

3 month Evaluation: 50 subjects

6 month Evaluation: 49 subjects

12 month Evaluation: 46 subjects

Primary Endpoint
Effectiveness Results

Bruce J. Gantz, MD
Principal Investigator
University of Iowa
Topics

• Speech Perception Outcomes
  – Co-primary and secondary endpoints
  – Performance in the Combined Condition (Everyday)
  – Performance over time
  – Performance in different listening conditions

• Other efficacy outcomes
  – Music Perception
  – Self Assessment Questionnaires
<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Average (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at Implantation</td>
<td>64.1 years (±14.7)</td>
</tr>
<tr>
<td>Gender</td>
<td>50% males, 50% females</td>
</tr>
<tr>
<td>Ear Implanted</td>
<td>24 left, 26 right</td>
</tr>
<tr>
<td>Duration of High Frequency Hearing Loss</td>
<td>28.1 years (±14.9)</td>
</tr>
<tr>
<td>Duration of Severe to Profound High Frequency Hearing Loss</td>
<td>13.7 years (±7.2)</td>
</tr>
<tr>
<td>Preoperative Aided CNC Score – Implant Ear</td>
<td>28.4% (±14.7%)</td>
</tr>
<tr>
<td>Preoperative Aided AzBio Sentence Score (+ 5dB SNR) – Implant Ear</td>
<td>16.3% (±14.4%)</td>
</tr>
</tbody>
</table>
Co-Primary and Secondary Study Endpoints: 6 Months
Co-Primary Endpoints: Implant Ear 6 Months (N=50$^1$)

Study Endpoints met – more than doubled mean scores

![Graph showing CNC Words and AzBio +5dB SNR percentages with significant improvements.]
### Secondary Endpoints – Implant Ear

#### Secondary Endpoint thresholds greatly exceeded for quiet and noise

<table>
<thead>
<tr>
<th></th>
<th>% Who Performed Same or Better (N=50)</th>
<th>Better</th>
<th>Same</th>
<th>Poorer</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNC Words</td>
<td>96%</td>
<td>40/50 (80%)</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>48/50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNC Phonemes</td>
<td>90%</td>
<td>42/50 (84%)</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>45/50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AzBio Sentences (Noise)</td>
<td>88%</td>
<td>36/50 (72%)</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>44/50</td>
<td></td>
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</tbody>
</table>

1. Data reported here are based on the data using LOCF (N=50); counted as “poorer”
Everyday Use Results:
(Combined Mode) Both Ears
Speech perception significantly improved in both and quiet and noise

*Everyday Use Results - Both Ears (N=50¹)*

Data reported here are based on the data using LOCF (N=50);
### Everyday Use Results - Both Ears

100% of subjects performed the same or better postoperatively

<table>
<thead>
<tr>
<th>% Who Performed Same or Better (N=50)</th>
<th>Better</th>
<th>Same</th>
<th>Poorer</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNC Words</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>100%</td>
<td>43/50 (86%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>50/50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNC Phonemes</td>
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</table>

1Data reported here are based on the data using LOCF (N=50); counted as “poorer”
Performance Over Time
In both the Hybrid and combined conditions; Significant improvement pre to 3, 6 &12 months; p<0.0001
AzBio Sentences in Noise at + 5 dB SNR Over time (Implant Ear & Both Ears)

In both the Hybrid and Combined conditions; Significant improvement pre to 3, 6 &12 months; p<0.0001
Performance on Word Recognition: Different Listening Conditions
### CNC Word Recognition in different listening conditions at 6 months

<table>
<thead>
<tr>
<th>Listening Conditions</th>
<th>Percent Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preoperative Acoustic</td>
<td>28%</td>
</tr>
<tr>
<td>Preoperative Bilateral</td>
<td>43%</td>
</tr>
<tr>
<td>Postoperative Acoustic</td>
<td>18%</td>
</tr>
<tr>
<td>Postoperative Electric</td>
<td>52%</td>
</tr>
<tr>
<td>Postoperative Hybrid</td>
<td>70%</td>
</tr>
<tr>
<td>Postoperative Combined</td>
<td>80%</td>
</tr>
</tbody>
</table>

N=38
Other Efficacy Assessments

Pitch Perception
Self Assessment Questionnaires
UW-CAMP: Pitch Direction Discrimination

Pitch perception capabilities not impacted

N=10

Hybrid L24 Subjects (N=46)

Normally Hearing (NH) score from (Kang et al., 2009)
Speech Spatial and Quality of Sound Scale
6 Months

Significant benefit across all subscales

** Significant different from preoperative at p<0.0001

* Significant different from preoperative at p<0.01

(Noble et al., 2009)
Subjects reported higher satisfaction levels postoperatively.

### Preoperative
- Dissatisfied: 8% (4/48)
- Neutral: 17% (8/48)
- Satisfied: 75% (36/48)

### Postoperative
- Dissatisfied: 6% (3/48)
- Neutral: 15% (7/48)
- Satisfied: 79% (38/48)
Subjects reported higher levels of satisfaction across various situations.
Summary

- The primary and secondary study endpoints were met
  - In the implant ear; 80% and 72% of subjects demonstrated significant improvements in quiet and noise
- SSQ results corroborate speech perception results
- 79% of the subjects reported being satisfied/very satisfied with hearing performance in their postoperative condition
- 100% of subjects showed equal or greater speech perception performance when listening in the Everyday Condition
Safety Results

J. Thomas Roland, Jr., MD
Lead Investigator
NYU Medical Center
Medical/Surgical and/or device-related events were recorded as AEs for any subject at any time during the course of the entire study.

Data reported as the number and proportion of individuals experiencing the AE.

Medical/surgical events included instances of hearing loss, increased tinnitus, vertigo, and other symptoms.

Many of the AEs are typical of those seen in any ear surgery.
Adverse Events

- 65 adverse events were reported involving 34 of 50 subjects over the course of the study
  - 43 events were very consistent in the type and proportion of events seen in other cochlear implant studies. All but 2 AE’s resolved.
  - 22 cases of Profound/Total hearing loss - categorized as an AE for the first time in industry history
## Adverse Events > 5% Incidence

<table>
<thead>
<tr>
<th>Event</th>
<th># of Events</th>
<th>% Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased tinnitus</td>
<td>14</td>
<td>100%</td>
</tr>
<tr>
<td>Open/Short circuited electrodes</td>
<td>11</td>
<td>100%</td>
</tr>
<tr>
<td>Dizziness type symptoms</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>All Other*</td>
<td>9</td>
<td>78%</td>
</tr>
<tr>
<td>Profound/Total loss</td>
<td>22</td>
<td>0%</td>
</tr>
<tr>
<td><strong>All Events</strong></td>
<td><strong>65</strong></td>
<td><strong>--</strong></td>
</tr>
</tbody>
</table>

* Sound quality issues, decreased performance, skin irritation, overstimulation, pain with effusion, local stitch infection
## Unresolved Adverse Events

<table>
<thead>
<tr>
<th>Event</th>
<th># of Events</th>
<th>% of Events</th>
<th># of Subjects with Event</th>
<th>% of Subjects with Event</th>
<th>% Resolved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profound/Total Loss</td>
<td>22</td>
<td>34%</td>
<td>22</td>
<td>44%</td>
<td>0%</td>
</tr>
<tr>
<td>Sound Quality</td>
<td>2</td>
<td>3%</td>
<td>2</td>
<td>4%</td>
<td>50%</td>
</tr>
<tr>
<td>Decreased Performance</td>
<td>1</td>
<td>2%</td>
<td>1</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### TWO CASES

- One sound quality issue unresolved despite programming changes
- One decrease in performance possibly unrelated to prior total loss of hearing
Summary

• No Unanticipated Adverse Device Effects have been reported
• Hybrid L24 AEs consistent in terms of severity, type and number of events as observed in the Nucleus Freedom clinical trial
• AEs regarding loss of residual hearing not previously reported in CI studies as total loss was assumed
Hearing Sensitivity
Hearing Sensitivity Outcomes

• There are 2 ways to assess hearing sensitivity over time:
  – The amount of low frequency hearing loss induced by implantation
  – The degree of residual low frequency hearing

• It is important to convey both the amount of hearing lost and the functional impact of that loss on the ability to combine electric and acoustic hearing in the implanted ear
  – Hearing sensitivity is one of many measures used to assess outcomes in the Hybrid population
Amount of hearing loss: 6 and 12 months

At 6 months, subjects experienced on average a 33 dB change in low frequency pure tone average

<table>
<thead>
<tr>
<th>Change in LF PTA (125-1k Hz)</th>
<th>Number of Subjects</th>
<th>Subgroups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 months (N=50)</td>
<td>12 months (N=46)</td>
</tr>
<tr>
<td>≤ 30 dB</td>
<td>27 (54%)</td>
<td>27 (59%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 30 dB</td>
<td>23 (46%)</td>
<td>19 (41%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Outcomes by Hearing Loss

CNC Word Recognition N=48

AzBio +5dB SNR N=48

Change in LF Hearing

Percent Correct

Acoustic Alone Pre
Hybrid Mode 6m

< 10
N=12

10 <= 20
N=12

20 <= 30
N=3

> 30
N=21

< 10
N=12

10 <= 20
N=12

20 <= 30
N=3

> 30
N=21

Electric Plus
Acoustic
Clinical Significance of Groups 1 and 2

CNC Word Recognition 6 Months Postactivation N=48

AzBio +5dB SNR 6 Months Postactivation N=48

Percent Correct

Degree of LF Hearing

Severe or Better Group 1 (n=33) Profound/Total Group 2 (n=15)

Severe or Better Group 1 (n=33) Profound/Total Group 2 (n=15)

Electric Plus Acoustic
Clinical Significance of Groups 1 and 2

CNC Word Recognition
6 Months Postactivation N=48

AzBio +5dB SNR
6 Months Postactivation N=48

Percent Correct

0 10 20 30 40 50 60 70 80 90 100

Acoustic Alone Pre
Hybrid Mode 6m

Severe or Better
Group 1
N=33

Profound/Total
Group 2
N=15

p<0.0001
p<0.05

Severe or Better
Group 1
N=33

Profound/Total
Group 2
N=15

p<0.0001
Everyday Use Outcomes:
Both Ears – Group 2 - Profound/Total Loss

- **CNC Words**
  - Preoperative
  - 6 Month
  - Acoustic Alone
  - Combined Mode
  - Pre to Post significant, p < .001

- **AzBio Sentences**
  - Preoperative
  - 6 Month
  - Acoustic Alone
  - Combined Mode
  - Pre to Post significant, p < .001
• 44% Profound/Total Losses
• 17/22 at 6 months
• 5 additional post 6 months
Revision Cases

- 6 Subjects have undergone revision surgery as of today
  - 4 subjects were explanted and reimplanted with a cochlear implant (full array) as of the May 31 database closure
    - All 4 cases experienced profound/total low frequency hearing loss, dissatisfaction, and poor performance in the implanted ear
    - Straight-forward revision procedure
      - Not impacted by prior Hybrid implantation
    - Post-revision data for these four subjects demonstrates improved performance when compared to the subjects’ preoperative and pre-revision scores
- 2 additional subjects have been reimplanted after database closure

FDA was not provided data regarding two subjects reimplanted after database closure as part of the original PMA submission as data was not available until October 2013.
## Potential Predictive Factors – Hearing Sensitivity

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Gender P-value*</th>
<th>Age P-value</th>
<th>Duration of Loss P-value*</th>
<th>Duration of Severe to Profound Loss P-value*</th>
<th>Etiology P-value*</th>
<th>Baseline CNC Score P-value*</th>
<th>Baseline AzBio Score P-value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change LFHL</td>
<td>0.010</td>
<td>0.160</td>
<td>0.722</td>
<td>0.275</td>
<td>0.970</td>
<td>0.450</td>
<td>0.900</td>
</tr>
<tr>
<td>Degree LFHL</td>
<td>0.016</td>
<td>0.088</td>
<td>0.536</td>
<td>0.581</td>
<td>0.949</td>
<td>0.910</td>
<td>0.264</td>
</tr>
</tbody>
</table>

*ANOVA p-value.
Summary – Hearing Sensitivity

• Hearing sensitivity is one of many measures used to assess outcomes in the Hybrid clinical study.

• Assessment of residual hearing by:
  – Amount of hearing lost (pre to post change)
  – Degree of residual low-frequency hearing

• Those who maintain functional hearing (Group 1) are able to use A + E in the implant ear.

• While 6 subjects underwent revision surgery due to poor performance/dissatisfaction, post-revision performance improved over hearing aids in the 5 subjects with data available.

• Longitudinal low frequency PTA data supports stability beyond 6 months.
Labeling and Post-Approval Summary

Sean Bundy
Director, Regulatory Affairs
Labeling for Unilateral Use

• Current Cochlear Implant labeling is silent on bilateral vs. unilateral use

• Proposed Hybrid labeling is implicitly unilateral:
  – “The CNC word recognition score… in the contralateral ear will be equal to or better than that of the ear to be implanted”

• Explicit contraindication may unnecessarily constrain physicians’ options when medically appropriate
Necessity for Hearing Aid Trial

- Subjects in trial had significant history of hearing aid use (average of 18+ years)
- Most subjects presented with hearing aids that were adequately fit and required no adjustment
- No subject was removed from candidacy through the hearing aid trial
  - Three subjects elected to continue with amplification and not pursue implantation
Access to Patients Under Age 22

• Historically, ‘adult’ cochlear implant indications have used 18 years of age
• There are no anatomical differences between an 18-year old and 22 year-old cochlea that support limiting the age
• Results in both standard length arrays and with the Hybrid L24 indicate good outcomes at younger ages
• No compelling reason to deny access to 18-21 year olds
• Only candidates who met the hearing loss profile would be candidates for the device
• Cochlear does not believe limiting use of the device to individuals 22 years or older is clinically necessary
Hybrid Post Approval Study Synopsis

Extended Duration
- Subjects from the original IDE study invited to participate
- Observation to 5 years
- Safety: Continue safety monitoring pre protocol
- Effectiveness: speech perception, hearing sensitivity and self assessments
- Data gathered at annual intervals

Newly Implanted
- 50 subjects, 18 years and up from up to 25 centers
- Observation to 3 years
- Safety: monitoring consistent with IDE protocol
- Effectiveness: speech perception, hearing sensitivity and self assessments
- Data gathered at initial activation, 6, 12, 24 and 36 months postactivation
Post-Approval Study Questions

• Extended Duration
  – Impact of new CP900 features expected to be negligible
    • Will be deactivated during PAS testing
  – CNC and AzBio measures will be gathered at all intervening time points, primary endpoint will be 5 years
  – Historically, 5 years is longest time point for CI Study

• Newly Implanted
  – CNC and AzBio allow comparison to existing data; exhaustive additional measures can harm recruitment and retention
  – Modified DUQ allows for comparison to pivotal study – HUI included to assist in reimbursement decisions
  – Long-term retention studying commercial device can be problematic; 3 years is manageable, while still yielding long term data
Risk Benefit Assessment

J. Thomas Roland, Jr., MD
Lead Investigator
NYU Medical Center
Risk Benefit Assessment

- Success in primary and secondary endpoints demonstrate objective improvement in perception:
  - Clinically significant improvement in mean CNC and AzBio scores in the implant ear
  - More than 75% of subjects experienced a significant improvement in speech understanding in both quiet and noise in the implant ear

- When evaluated in the everyday use condition (both ears), all subjects were equivalent or better with respect to speech performance
Risk Benefit Assessment

Subjective Benefits

• Significant benefit perceived by subjects across domains of hearing related to speech perception, spatial hearing, and sound quality domains

• Postoperatively, 79% of subjects reported being very satisfied or satisfied
  – Only 8% of subjects reported being satisfied or very satisfied preoperatively
Well-Characterized, Acceptable Risks

- Adverse events associated with surgery were consistent with those observed in comparable ear surgeries.
- 44% of subjects experienced profound/total loss of hearing at some point during the study (IA-48 months).
- At the 6 month interval subjects with profound total loss demonstrated the following outcomes:
  - In the implanted ear, 15/17 (88%) scored the same or better on CNC Words, and 11/17 (65%) scored the same or better on AzBio Sentences.
  - In the implanted ear, 8/50 subjects did not show improvement in speech perception and tended to be dissatisfied.
  - In Everyday Use, all subjects scored the same or better on both CNC words and AzBio sentences.
Risk Benefit Assessment

Analysis

• The Hybrid L24 Implant provides a better treatment option than amplification alone for suitable candidates with high frequency hearing loss

• The majority of subjects were able to combine high frequency information provided by the Hybrid L24, not available via acoustic hearing aids alone, with low frequency acoustic information from one or both ears

• Benefits of implantation with the Hybrid Cochlear Implant System outweigh associated risks

• Appropriate labeling will allow counseling regarding the risks and benefits of the treatment
Conclusions

• The study met all primary and secondary efficacy endpoints with no Unanticipated Adverse Device Effects.

• The Hybrid L24 Implant System is an integrated electric-acoustic (EAS) solution, a new option for a patient population that currently has few therapeutic alternatives.
  – Improved speech perception in quiet and in noise was observed beyond that seen historically with CI, particularly when functional hearing was maintained in the implant ear and both ears.

• Most subjects reported being very satisfied or satisfied with the hybrid implant.
Conclusions

• The data in this application demonstrate a reasonable assurance of safety and effectiveness for individuals meeting indications for the device

• Results support the conclusion that the benefits of the Hybrid L24 Implant System outweigh the risks for individuals meeting indications for the device
Backup Slides Shown
Distribution of CNC Scores Contralateral Ear
Post Revision Results: CNC Words Implant Ear

S: Significant improvement post revision CI Alone compared to both preop. Acoustic alone and pre-revision Hybrid score.
CNC Word Recognition
6 Months Postactivation

Freedom vs. Hybrid CNCs

- Hybrid Mode > Freedom p = 0.01
- Hybrid Mode > Hybrid E Only p < 0.001
- Freedom vs Hybrid E NS

Medians:
- F = 54
- H = 71
- HE = 54.5

Means:
- Freedom: 53.6
- Hybrid Mode: 64.2
- Hybrid E Only: 50.0

N=53, N=50, N=50
CNC Word Recognition
6 Months Postactivation

Percent Correct

Medians
F = 54
H = 82
HE = 37

Mean = 53.6
Mean = 76.0
Mean = 40.6

Freedom vs. Hybrid CNCs – Gp 1 & 2

Hybrid Mode > both CI conditions (p < 0.001)
Freedom vs Group 2 NS
### Subjects Preoperatively Satisfied with Hearing Aids

<table>
<thead>
<tr>
<th>Subject ID</th>
<th>Preop Acoustic Alone CNC Words</th>
<th>6 Month Hybrid CNC Words</th>
<th>12 Month Hybrid CNC Words</th>
<th>Preop Satisfaction</th>
<th>6 Month Device Satisfaction</th>
<th>12 Month Device Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.0</td>
<td>70.0</td>
<td>66.0</td>
<td>Satisfied</td>
<td>Dissatisfied</td>
<td>Very Dissatisfied</td>
<td></td>
</tr>
<tr>
<td>59.0</td>
<td>18.0</td>
<td>16.0</td>
<td>Very Satisfied</td>
<td>Dissatisfied</td>
<td>Neutral</td>
<td></td>
</tr>
<tr>
<td>33.0</td>
<td>76.0</td>
<td>61.0</td>
<td>Satisfied</td>
<td>Very Satisfied</td>
<td>Very Satisfied</td>
<td></td>
</tr>
<tr>
<td>48.0</td>
<td>80.0</td>
<td>80.0</td>
<td>Very Satisfied</td>
<td>Very Satisfied</td>
<td>Very Satisfied</td>
<td></td>
</tr>
</tbody>
</table>
Bimodal Results Over Time

Bimodal Results Over Time

CNC Scores (%)

- Preop Bilateral Acoustic CNC Words
- 6 Month Bimodal CNC Words
- 12 Month Bimodal CNC Words

All (n=50)

44.9
76.1
78.8
## Univariable and Multivariable Models for Change in LFHL

<table>
<thead>
<tr>
<th>Subject Characteristic</th>
<th>Univariable</th>
<th></th>
<th>Multivariable</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimate</td>
<td>P-value</td>
<td>Estimate</td>
<td>P-value</td>
</tr>
<tr>
<td>Gender</td>
<td>-19.6</td>
<td>0.008</td>
<td>-15.6</td>
<td>0.047</td>
</tr>
<tr>
<td>Age</td>
<td>0.50</td>
<td>0.052</td>
<td>0.39</td>
<td>0.178</td>
</tr>
<tr>
<td>Duration of hearing loss</td>
<td>0.12</td>
<td>0.637</td>
<td>-0.19</td>
<td>0.522</td>
</tr>
<tr>
<td>Duration of severe hearing loss</td>
<td>-0.29</td>
<td>0.580</td>
<td>-0.60</td>
<td>0.262</td>
</tr>
<tr>
<td>CNC Words</td>
<td>0.29</td>
<td>0.266</td>
<td>0.48</td>
<td>0.093</td>
</tr>
<tr>
<td>Low-frequency hearing threshold</td>
<td>0.48</td>
<td>0.203</td>
<td>0.89</td>
<td>0.032</td>
</tr>
</tbody>
</table>

Analysis similar to FDA analysis for speech perception (includes LOCF imputation)

Results indicate gender most consistent predictor.
Post Revision Results: CNC Words  Bimodal Condition

S: Significant improvement post revision (bimodal) over preop bilateral acoustic
also significant improvement over pre-revision Hybrid L24 (bimodal)
Figure 14: Mean pre- and postoperative CNC and AzBio sentences-in-noise scores for the implanted ear by site
Hearing Sensitivity by Site

Mean Change in LFHL

Site Effects

Change in LFHL (dB)

Site ID

Site ID

N
A
B
C
D
E
F
G
H
I
J

N
6
3
10
11
3
7
3
3
1
3
Summation

Bruce Gantz, MD
Principal Investigator
University of Iowa
Unmet Need

- Individuals experience significant hearing difficulty and fail in their social and work environments.
- The Hybrid L24 Implant provides a better treatment option than amplification alone for suitable candidates with high frequency hearing loss.
- Presently this population has no treatment options.
Original Questions

• Based on inadequate treatment options and clear patient need the following questions arose:
  – Can we expand electrical speech processing to more of the hearing impaired population?
  – Is there a downside to implanting those with more residual hearing?
  – What are the advantages of preserving residual auditory function?
    • Spatial Hearing
    • Quality of Sound and Music
    • Hearing in Noise
Outcomes

• In the everyday (combined) condition
  – All patients are the same or better with this treatment
  – All those with functional acoustic hearing (Group 1 - <90dB PTA) receive the same benefit regardless of the magnitude of the change in hearing
  – Those without functional acoustic hearing (Group 2 - >90dB PTA) are benefiting from the Hybrid Implant in the bimodal condition

• Risk benefit is a discussion between the clinician and the patient