

Final Draft 3/17/08

CONFERENCE CALL REGARDING NEJM PUBLICATION OF AVIDAN STUDY
CALL SCHEDULED FOR MONDAY, MARCH 17, 2008 AT 10AM

FRB:

I'd like to thank everyone for joining us today. On March 12, 2008, we sent out a press release commenting on the publication of a study on anesthesia awareness and the Bispectral Index in the New England Journal of Medicine. If anyone has not received the release please call the Financial Relations Board at 312-266-7800 and my assistant will send you another copy.

Before we begin the call, we'd like to remind participants that certain statements in this conference call may constitute forward-looking statements within the meaning of the Private Securities Litigation Reform Act. These forward-looking statements include statements concerning the expected benefits of the BIS system, including its ability to reduce the incidence of awareness, and the Company's belief that anesthesiologists and other members of the anesthesia community will not rely upon the conclusions of the Avidan study. These statements involve risk and uncertainties. Among the factors that could cause actual events to differ materially from these forward-looking statements in this conference call are those set forth under the heading, "Risk Factors" in our Annual Report on Form 10-K for the year ended December 31, 2006 and our Quarterly Report on Form 10-Q for the fiscal quarter ended September 29, 2007, each as filed with the Securities and Exchange Commission.

In addition, any forward-looking statements represent our views only as of today and should not be relied upon as representing our views as of any subsequent date. While we may elect to update these forward-looking statements at some point in the future, we specifically disclaim any obligation to do so, even if our views change. Therefore, you should not rely on these forward-looking statements as representing our views as of any date subsequent to today.

With that said, I'd like to introduce Aspect's President and Chief Executive Officer, Mr. Nassib Chamoun. Nassib will begin the call by summarizing the Company's views about the study and the call will later be opened to your questions. Nassib you may go ahead.

NASSIB:

Thank you. Good morning and welcome. Joining me this morning are Dr. Scott Kelley, Aspect's Medical Director, Bill Floyd, our VP for Sales & Marketing, and Mike Falvey, our Chief Financial Officer. I will begin the call with some general comments about the study published in the New England Journal of Medicine. Dr. Kelley will provide the

perspective of a practicing anesthesiologist and an expert in brain function monitoring. We will then open the call for your questions.

In our view, there are only two conclusions that can reasonably be drawn from the study by Dr. Avidan published in the New England Journal of Medicine:

1. Awareness is a serious problem, and
2. BIS monitoring is a very effective tool to assist anesthesia professionals to reduce its incidence.

Unfortunately, the authors of the paper chose to draw a variety of other conclusions from the study that we do not believe are substantiated by the published material.

The good news is that now that many more anesthesiologists have had the opportunity to actually read the study, we have received numerous communications of support from a diverse group of anesthesiologists from around the world and from several of our largest customers. We have also heard from experts in brain-function monitoring, experienced clinical investigators, and statisticians, who have expressed serious questions about the design of the study, the quality of data that are presented, and the appropriateness of the authors' conclusions given the limitations of the study.

In the Avidan study, the authors chose to study a high-risk population that was expected to have an incidence of awareness of 1% under standard clinical practice conditions. This expected incidence of 1% was based on prior published studies.

The incidence of awareness observed in the BIS-monitored group in the Avidan study was 0.21% (or 2 per 1,000), compared to the expected incidence in high-risk patients of 1% (10 per 1,000). This 80% reduction in relative risk is consistent with the Myles B-Aware study as well as the SAFE-2 study that demonstrated that BIS-guided anesthesia assisted physicians to reduce the incidence of awareness by approximately 80%.

The Avidan dosing protocol tested for the first time in this study specified the use of an anesthetic regimen employing at least 0.7 MAC of volatile gas, as well as audible alarms on the anesthetic agent analyzer used to alert clinicians if they strayed from the predetermined dose range. For many years, proponents of volatile anesthetics have expressed the view that awareness could not occur, or that the incidence of awareness would be vanishingly small, if all patients were given this amount of anesthesia.

In the Avidan study, that premise was proven incorrect. Patients in the Avidan protocol group fared no better than the BIS-monitored population, although the study clearly did not have sufficient statistical power to adequately compare the relative effectiveness of two active interventions.

The study therefore presents a stark choice for anesthesia professionals. Even if you were to accept the view that managing anesthesia with the Avidan dosing protocol was proven to be equally effective as BIS monitoring for purposes of reducing the incidence of awareness - which the reported data does not, I repeat, does not have the statistical power to support - the question remains whether anesthesia professionals would be willing and able to utilize such a rigid protocol on a routine and consistent basis. Anesthesia professionals are accustomed to using a variety of tools, monitoring methods, and clinical judgment, in an effort to customize anesthesia for the individual needs of each patient. We do not believe they will sacrifice the control and flexibility this provides for the constraints of a formulistic one-size-fits-all dosing protocol.

With that, I will ask Dr. Kelley to provide his perspective.

SCOTT

Thank you Nassib.

Based on my discussions with many other clinicians and scientists over the past few days, there are many elements of the study and its interpretation that concern me.

1. The authors state that that the study “did not reproduce the results of previous studies and do not support routine BIS monitoring as part of standard practice”. These statements imply that the study attempted to reproduce those prior studies by comparing BIS monitoring to standard practice; in our view, the study clearly failed to do so. In the Avidan study, BIS monitoring was compared to an end-tidal gas dosing protocol, including the use of alarms, **that does not represent standard practice**. In our opinion, to suggest that this trial provides an accurate comparison between BIS and standard practice is simply false and misleading.

In fact, considering that the anesthesia teams were instructed to continuously focus on awareness, and to deliver the amount of volatile anesthesia indicated by the Avidan dosing protocol in an effort to minimize the risk of awareness, it is no surprise that this study found a relatively low incidence of awareness in the end-tidal gas protocol group.

From a scientific study design perspective, a statistically valid comparison of two different interventions to reduce anesthesia awareness would have required significantly more enrolled patients and a greater number of awareness case observations. The Avidan study was not sufficiently powered for the authors to draw any firm conclusions regarding the relative efficacy of two interventions, let alone their sweeping conclusions disparaging BIS monitoring that they have made in the article and in the press.

2. Unlike the Myles B-Aware study, no post-operative recovery or outcome data was provided by the authors, so it is not possible to determine the impact of Avidan’s gas dosing protocol on other important anesthetic endpoints. In contrast, numerous studies demonstrate the ability of BIS-guided anesthesia care to improve patients’ recovery profile, accelerate emergence from anesthesia, and reduce patients’ anesthetic requirements.
3. Monitoring patient response with BIS is designed to allow clinicians to ensure that patients are not exposed to more anesthesia than they need by measuring the effect of anesthesia rather than just the concentration of one agent. My anesthesia colleagues can therefore customize anesthesia for each patient based on their individual responses to anesthesia during the course of surgery. Avidan’s gas dosing protocol does not offer the same flexibility, choice or insight into patient responsiveness.
4. Based on BIS trends that have been published in several large studies, as well as my personal experience in thousands of cases using BIS, the BIS traces that are presented in the Avidan study are very troubling. Based on data provided in the paper, both cases of awareness in the BIS group most likely occurred at times early in the case when BIS values were not being displayed to the clinician. Both Patients 3&4 randomized to BIS-guided anesthesia care are lacking BIS information - which was supposed to be used to guide patient care, for 30-45 min immediately prior to or overlapping the period of awareness. Patient number 4 is

particularly concerning, as this episode of awareness - in the absence of any clarifying information from the authors - may reflect unintentional interruption of anesthetic delivery resulting from inadequate vigilance and adherence to expected norms of clinical care. Thus, these two cases appear to me, and to other experts with whom I have spoken, to be more likely due to a “failure to monitor” than a monitor failure.

5. The authors cite the cost of BIS monitoring if the technology was used routinely for all cases of general anesthesia, but fail to mention the demonstrated cost savings associated with its use. In a meta analysis of the available scientific literature published in Anesthesiology, Liu reported that use of BIS monitoring reduced anesthetic drug consumption by 19% and showed a residual cost of only ~\$5.50/ case, exclusive of the benefits derived from reducing the incidence of awareness.
6. Finally, in the conclusion of his paper, Avidan suggests that reliance on BIS technology “may provide patients and providers with a false sense of security about the reduction in the risk of anesthesia awareness”. Unfortunately, no monitoring technology can totally eliminate the risk of awareness. However, we believe that a reduction of approximately 80% in the incidence of awareness in high-risk patients compared to standard clinical practice represents a significant improvement in patient safety. And it is no surprise to me that thousands of anesthesia professionals throughout the world have demonstrated their confidence in BIS monitoring through the use of our technology in more than 25 million cases to date, both to assist them to reduce the incidence of awareness, and to improve patients’ experience and recovery profiles following general anesthesia.

The conversations we have had since Thursday’s publication echo and amplify anesthesia professionals’ confidence in both the efficacy of BIS monitoring and its broad impact on anesthetic management and patient care. Regarding any “false sense of security” provided by BIS monitoring – the greater concern to me following the publication of this study is the higher likelihood that patients have been misled into believing that the Avidan gas monitoring protocol represents standard clinical practice and would be used if they needed to undergo general anesthesia tomorrow.

I will close by saying that we plan to communicate all of our concerns about the Avidan study to the New England Journal of Medicine in the next several days.

I will now turn the call back to Nassib.

NASSIB:

Thank you Scott.

Before opening the call to your questions, I will make one final point:

In the editorial accompanying the study, Dr. Orser notes that “the widespread adoption of devices and other interventions must be based on ample peer-reviewed data”. We fully agree - and the reality is that the growth in utilization of BIS monitoring has paralleled the appearance of extensive scientific support including more than 20 prospective randomized clinical trials summarized in a recent Cochrane Library review, and more than 3,000 other publications and abstracts. We are not aware of any other device which has been so extensively studied.

We will now open the call to your questions.

OPERATOR:

Thank you. Ladies and gentlemen, if you have a question at this time, please press the one key on your touch-tone telephone. If your question has been answered, or you wish to remove yourself from the queue, please press the pound key. We also ask, that if you're using a speaker phone to please lift the handset before asking your question.

Q&A SESSION.....

THERE ARE NO FURTHER QUESTIONS. PLEASE CONTINUE WITH ANY CLOSING REMARKS.

NASSIB:

Thank you for your time and your questions this morning.

The Avidan study published in the New England Journal of Medicine last week was designed to refute the results of prior studies that have shown that BIS monitoring assists anesthesia professionals to reduce the incidence of anesthesia awareness. In our view, this

single-site study utterly fails to do so. With the exception of awareness, patient recovery and post-operative outcome endpoints are not reported, there are substantial and troubling gaps in BIS trends, and the study lacks the statistical power for the authors to draw the conclusions they have. As Scott mentioned earlier, we intend to bring the specifics of all of these issues, as well as what we believe are other inconsistencies, to the attention of the New England Journal of Medicine.

Scott, Mike and I will be in the office for the rest of the morning if you have any additional questions.