

<p>1 UNITED STATES PATENT AND TRADEMARK OFFICE 2 BEFORE THE PATENT TRIAL AND APPEAL BOARD 3 4 IMPERATIVE CARE, INC., 5 Petitioner, 6 7 v. 8 INARI MEDICAL, INC., 9 Patent Owner. 10 ----- 11 Case IPR2025-01021 12 ----- 13 VIDEOTAPED DEPOSITION OF AQUILLA S. TURK, III, D.O. 14 15 Wednesday, February 25, 2026 16 8:10 a.m. - 10:50 a.m. 17 18 81801 Overseas Highway 19 Islamorada, Florida 20 21 Stenographically Reported By 22 Pamela J. Pelino, RPR, FPR, CLR Notary Public, State of Florida PLANET DEPOS</p>	<p>1 - - - 2 I N D E X 3 - - - 4 AQUILLA S. TURK, III, D.O. DIRECT CROSS REDIRECT 5 BY MR. MILLER 5 6 7 8 9 10 - - - 11 N O E X H I B I T S M A R K E D 12 - - - 13 14 15 16 17 18 19 20 21 22</p>
<p>1 APPEARANCES: 2 On behalf of the Patent Owner: 3 JAMES MILLER, ESQUIRE 4 PERKINS COIE LLP 5 1301 2nd Avenue 6 Suite 4200 7 Seattle, Washington 98101-3099 8 206.359.8584 9 jmiller@perkinscoie.com 10 11 On behalf of the Petitioner: 12 JOSHUA STOWELL, ESQUIRE 13 KNOBBE MARTENS 14 2040 Main Street 15 14th Floor 16 Irvine, California 92614 17 949.760.0404 18 joshua.stowell@knobbe.com 19 20 Videographer: 21 FRANTZ CLERVIL 22</p>	<p>1 P R O C E E D I N G S 2 - - - 3 Deposition taken before Pamela J. Pelino, 4 Registered Professional Court Reporter and Notary 5 Public in and for the State of Florida at Large, in 6 the above cause. 7 - - - 8 THE VIDEOGRAPHER: Here begins Media 9 Number 1 in the videotaped deposition of 10 Dr. Aquilla Turk, III in the matter of 11 Imperative Care, Inc., versus Inari Medical, 12 Inc., in the court of the U.S. Patent and 13 Trademark Office, case number IPR2005-01021. 14 Today's date is February 25th, 2026. The 15 time on the video monitor is 8:10 a.m. 16 The videographer today is Frantz Clervil, 17 representing Planet Depos. This videotaped 18 deposition is being held at 80801 Overseas 19 Highway, Islamorada, Florida 33036. 20 Would counsel please voice identify 21 themselves and state whom they represent. 22 MR. MILLER: James Miller on behalf of</p>

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1 Inari Medical.  
2 MR. STOWELL: Joshua Stowell of Knobbe  
3 Martens on behalf of the petitioner,  
4 Imperative Care, and the witness.  
5 THE VIDEOGRAPHER: The court reporter  
6 today is Pamela Pelino representing Planet  
7 Depo. The witness will now be sworn in.  
8 Thereupon,  
9 ANQUILLA SCOTT TURK, III,  
10 having been first duly sworn or affirmed, responded  
11 and was examined and testified as follows:  
12 THE WITNESS: I do.  
13 COURT REPORTER: Thank you.  
14 DIRECT EXAMINATION  
15 BY MR. MILLER:  
16 Q. Good morning, Doctor.  
17 A. **Good morning.**  
18 Q. Would you please state your full name for  
19 the record.  
20 A. **Aquilla Scott Turk, III.**  
21 Q. I'm also a third.  
22 What is your current address?

6

1 A. **1617 Marsh Harbor Lane, Mount Pleasant,**  
2 **South Carolina 29464.**  
3 Q. You've been deposed; right?  
4 A. **Yes.**  
5 Q. So you probably know some of the ground  
6 rules, but I'm going to go over a few things so the  
7 record is clear today and we're on the same page.  
8 Does that sound good?  
9 A. **Yes.**  
10 Q. You understand that you're under oath?  
11 A. **Yes.**  
12 Q. Do you understand that at the conclusion  
13 of this deposition you're going to be given a  
14 transcript and so you'll have an opportunity to  
15 correct any errors in the testimony you provided  
16 today?  
17 A. **Yes.**  
18 Q. If you have any substantive changes that  
19 you make, they may be commented upon and may affect  
20 your credibility.  
21 Do you understand that?  
22 A. **Yes.**

7

1 Q. If at anytime there is something you  
2 don't understand or you don't hear me, I ask that  
3 you request clarification at the time.  
4 Does that sound good?  
5 A. **Okay.**  
6 MR. MILLER: Can we go off the record?  
7 THE VIDEOGRAPHER: Going off the record.  
8 The time now is 8:12 a.m.  
9 (Discussion held off the record.)  
10 THE VIDEOGRAPHER: Going back on the  
11 record. The time now is 8:14 a.m.  
12 BY MR. MILLER:  
13 Q. And that was a good example of there may  
14 be interruptions during our deposition. I would ask  
15 that -- I will try to reask my question, but I would  
16 ask that we finish the line of questioning before we  
17 take a break.  
18 Does that sound fair?  
19 A. **Yes.**  
20 Q. To make things easier for the court  
21 reporter today, let's avoid speaking at the same  
22 time. I'll try to wait for you to finish an answer

8

1 before I ask my next question. I ask that you do  
2 the same when I am asking a question.  
3 Does that sound fair?  
4 A. **Yes.**  
5 Q. I also ask that you give an audible  
6 response to my questions so that the court reporter  
7 may write down your response.  
8 Does that sound good?  
9 A. **Yes.**  
10 Q. Is there any reason you can't give your  
11 full and complete and truthful testimony today?  
12 A. **No.**  
13 Q. And I know that you have your foot, but  
14 are you on any medications or any -- do you have any  
15 other health conditions that might prevent you from  
16 giving full and complete testimony today?  
17 A. **No.**  
18 Q. And again, if at any time you need a  
19 break, as I mentioned before, we'll try to finish  
20 whatever question is pending before we take a break.  
21 But I understand if you really need to take a break  
22 for your foot, we can just cut it off.

<p>9</p> <p>1 A. Sure.</p> <p>2 Q. Not your foot, the question.</p> <p>3 A. <b>Foot would be better, might be a better</b></p> <p>4 <b>choice.</b></p> <p>5 Q. Did you bring any documents with you</p> <p>6 today?</p> <p>7 A. No.</p> <p>8 Q. Did you do preparation for your</p> <p>9 deposition today?</p> <p>10 A. Yes.</p> <p>11 Q. What did you do to prepare for today's</p> <p>12 deposition?</p> <p>13 A. <b>They -- Josh sent me a binder that had my</b></p> <p>14 <b>last -- my last deposition. I spent about 30</b></p> <p>15 <b>minutes review -- brisking through that. And then</b></p> <p>16 <b>we met yesterday for about an hour, hour and a half.</b></p> <p>17 Q. And you said your last deposition.</p> <p>18 Was that the deposition you provided in</p> <p>19 connection with the district court litigation?</p> <p>20 A. <b>I think so. I've only done one, so...</b></p> <p>21 Q. Okay. Do you recall what other documents</p> <p>22 were in the binder besides the deposition</p>	<p>11</p> <p>1 THE VIDEOGRAPHER: Counsel, we need to go</p> <p>2 off the record.</p> <p>3 The time now is 8:18 a.m. We are now</p> <p>4 going off the record.</p> <p>5 (Discussion held off the record.)</p> <p>6 THE VIDEOGRAPHER: We are back on the</p> <p>7 video record. The time now is 8:19 a.m.</p> <p>8 BY MR. MILLER:</p> <p>9 Q. Sorry about that.</p> <p>10 Other than meeting with your attorney and</p> <p>11 reviewing documents, did you do any other</p> <p>12 preparation for today's deposition?</p> <p>13 A. No.</p> <p>14 Q. Do you bill your time for this matter?</p> <p>15 A. No.</p> <p>16 Q. How many hours in total do you think</p> <p>17 you've spent working on or assisting with the IPRs</p> <p>18 in the Imperative Medical IPRs against Inari?</p> <p>19 A. <b>No idea. But not many.</b></p> <p>20 Q. Would you say less than 40?</p> <p>21 A. <b>Oh, yeah, by a lot.</b></p> <p>22 Q. You've provided declarations in several</p>
<p>10</p> <p>1 transcript?</p> <p>2 A. <b>There -- whatever articles or whatever</b></p> <p>3 <b>you call them, exhibits, whatever that -- were</b></p> <p>4 <b>associated with it. They seem to mostly be old</b></p> <p>5 <b>articles on aspiration, that I -- most of the ones</b></p> <p>6 <b>that I published, and a summary of, I guess, my</b></p> <p>7 <b>deposition.</b></p> <p>8 Q. So besides reviewing the deposition</p> <p>9 materials in the district court litigation and</p> <p>10 meeting with Josh for about an hour, did you do</p> <p>11 anything else to prepare?</p> <p>12 A. No.</p> <p>13 Q. How long would you say you spent</p> <p>14 preparing for today's deposition in total?</p> <p>15 A. <b>So as I said a minute ago, I spent</b></p> <p>16 <b>probably 20 minutes or so just briefing through</b></p> <p>17 <b>those documents just to see what they were. I</b></p> <p>18 <b>didn't review them in detail. And then yesterday we</b></p> <p>19 <b>met for a little over an hour.</b></p> <p>20 Q. And only Josh was at that meeting?</p> <p>21 A. <b>Well, my wife was running around the</b></p> <p>22 <b>house as well, but...</b></p>	<p>12</p> <p>1 IPRs that Imperative has filed against Inari</p> <p>2 patents; correct?</p> <p>3 A. <b>If you say so.</b></p> <p>4 <b>I don't know what IPR is, but I've given</b></p> <p>5 <b>my opinions on matters about thrombectomy and things</b></p> <p>6 <b>that I know. Things about patents I have no idea.</b></p> <p>7 <b>I don't give judgments about that. So however those</b></p> <p>8 <b>get translated into is what you have.</b></p> <p>9 Q. We'll probably be talking about IPRs a</p> <p>10 little bit here. They're inter partes reviews.</p> <p>11 That's what Imperative has filed against Inari. I'm</p> <p>12 going to be using some numbers throughout. For</p> <p>13 instance, I may refer to IPR2025-01021, and I will</p> <p>14 probably collectively call them "the IPRs," but it</p> <p>15 will refer to a certain -- a couple numbers. I will</p> <p>16 go ahead and say them for the record and maybe we</p> <p>17 can just come to an agreement that when I say "the</p> <p>18 IPRs," you know I'm referring to those three.</p> <p>19 Does that sound fair?</p> <p>20 A. <b>Sure.</b></p> <p>21 Q. Okay. So you've offered declarations in</p> <p>22 IPR2025-01021, IPR2025-01025, IPR2025-01264.</p>

13  
1 Does that sound fair?  
2 **A. If -- if the document says it is, then I**  
3 **did.**  
4 Q. And I'll put -- I'll put one of those  
5 declarations in front of you shortly.  
6 **A. Sure.**  
7 Q. But I'm going to collectively refer to  
8 those three IPRs as just the IPRs going forward.  
9 Save the court reporter her fingers.  
10 **A. Sure.**  
11 Q. Other than counsel in this matter, have  
12 you discussed your testimony, declaration or any  
13 other aspects with anyone else?  
14 **A. No.**  
15 Q. So you have not discussed your  
16 involvement with the IPRs with anyone at Imperative?  
17 **A. No.**  
18 Q. You're employed at Imperative; correct?  
19 **A. Yes.**  
20 Q. What is your current role?  
21 **A. Chief medical officer.**  
22 Q. What do you do in that role?

14  
1 **A. A lot of things. You know, I was one of**  
2 **the founders of Imperative Care as well. But we've**  
3 **helped them set strategies as far as devices for the**  
4 **pipeline, for future iterations and use in, you**  
5 **know, years to come.**  
6 **I review medical safety issues. So if**  
7 **there's any issues of a device malfunction or issue**  
8 **in a case or something, we're not clear if there is**  
9 **an issue with a device in a case and that's why**  
10 **there is an event, I'll review those.**  
11 **Looking at risk stratification for**  
12 **devices that are in the -- in the works. You know,**  
13 **a lot of regulatory documents, setting strategy for**  
14 **regulatory approval for devices. It kind of runs**  
15 **the full gamut.**  
16 Q. Were you involved in the decision-making  
17 to file the IPRs against Inari?  
18 **A. No.**  
19 Q. Do you hold any other roles at  
20 Imperative?  
21 **A. No.**  
22 Q. Do you hold any roles in any other

15  
1 companies?  
2 **A. No.**  
3 Q. How much are you compensated as the chief  
4 medical officer of Imperative?  
5 **A. \$250,000 a year.**  
6 Q. Do you own equity in Imperative?  
7 **A. Yes.**  
8 Q. How much?  
9 **A. A lot.**  
10 Q. Do you receive equity on a yearly basis?  
11 **A. No. My equity was purchased when we**  
12 **founded the company ten years ago and in it's very**  
13 **early stages.**  
14 Q. Do you know roughly what percentage of  
15 the company you own?  
16 **A. I don't know what it is currently, but at**  
17 **the -- at one point, I think it was around a percent**  
18 **and a half.**  
19 Q. Okay. I'd like to keep talking about  
20 your background a little bit more, but kind of pivot  
21 from Imperative to more your kind of technical  
22 expertise.

16  
1 **A. Sure.**  
2 Q. Can you briefly describe your education?  
3 **A. How far back?**  
4 Q. Kind of probably college onward.  
5 **A. Okay. Started college in Atlanta at a**  
6 **junior college and worked full-time most of the --**  
7 **first couple of years.**  
8 **Then went to the University of Florida**  
9 **when I finally decided I needed to get my life**  
10 **together. Did undergrad there.**  
11 **Went to Southeastern University in Miami**  
12 **for medical school.**  
13 **Started my residency at the Cleveland**  
14 **Clinic in Cleveland, Ohio. Did my first year there,**  
15 **then transferred to University of Wisconsin.**  
16 **Finished my residency there. Stayed there and did**  
17 **my fellowship. I was faculty and did my fellowship**  
18 **there.**  
19 **Did one year of private practice in**  
20 **Dallas, Texas. It wasn't a good fit, so went back**  
21 **to Madison. Was likely there for about four years,**  
22 **and then my wife said that seasonal effective**

<p style="text-align: center;">17</p> <p>1 disorder is real and we needed to move back to where 2 it's warm. So we took a job in Charleston, 3 South Carolina. I was at USC for 11 -- almost 11 4 years. 5 And then the last eight years or so, I've 6 been at Prisma Health in Greenville, South Carolina, 7 which is where I'm at currently. 8 Q. What is your current specialty? 9 A. Neurovascular surgery. 10 Q. Has that always been what you've worked 11 in or have you worked in other areas? 12 A. Yes, I've always done -- in the very 13 beginning of my career, I did -- I did -- my 14 specialty has always been neuroradiology and 15 neurovascular surgery or interventional radiology. 16 There's different terms people use for it. But in 17 the beginning, I did neurovascular surgery and 18 neuroradiology, meaning reading the films. 19 (Reporter clarification.) 20 THE WITNESS: So neuroradiology is 21 reading MRIs and CTs of the head and spine. 22 Neurovascular surgery is doing procedures on</p>	<p style="text-align: center;">19</p> <p>1 hear about where an arm or leg doesn't work right, 2 and that's called an ischemic stroke. And that's 3 from a blockage. And we go in and open that blood 4 vessel up and hopefully restore blood flow before 5 any permanent damage is done. 6 Q. And so the ischemic stroke, is that fair 7 to describe as being caused by like a clot? And I'm 8 not a doctor, so a clot or an embolism? 9 A. Yes. 10 Q. Do you use specialized devices to 11 treat the or to clear out the clots or embolisms in 12 neurovascular surgeries? 13 A. Yes. 14 Q. What kind of devices? 15 A. We typically use aspiration catheters. 16 So it's a catheter that's designed to go into the 17 blood vessels in the brain and remove the clot. 18 Q. How many years have you been practicing 19 neurovascular surgeries would you say? 20 A. Almost 25. 21 Q. How much training and practice do you 22 think someone needs to be able to successfully treat</p>
<p style="text-align: center;">18</p> <p>1 the blood vessels of the brain and spine. In 2 my first four or five years I also did 3 interventional radiology, which is the body, 4 you know, meaning, you know, the visceral 5 organs as well. 6 BY MR. MILLER: 7 Q. Uh-huh. 8 So focusing on the neurovascular surgery 9 side of things, what does that generally entail? 10 Like at a high level, what are you working -- trying 11 to solve? 12 A. Yes, I mean, the -- the easiest way to 13 explain that in lay terms is we're basically 14 plumbers -- 15 Q. Uh-huh. 16 A. -- for the brain and the spine. 17 And people typically have strokes, 18 meaning a bleeding stroke, which think about it as 19 leaking. So an aneurysm that bursts or a vascular 20 malformation that bursts. So we go in and stop the 21 bleeding and repair whatever the cause was. 22 The other type of stroke is one we more</p>	<p style="text-align: center;">20</p> <p>1 cerebral embolisms or to clear a clot from the 2 brain? 3 MR. STOWELL: Objection. Vague. 4 THE WITNESS: I think they need 5 specialized training in it. 6 BY MR. MILLER: 7 Q. Such as going to like medical school, 8 fellowship? 9 A. I mean, residency and fellowship, yeah. 10 Fellowship on top of residency for sure. 11 I may have said that backwards. 12 Fellowship on top of residency. 13 Q. Would training -- would that medical 14 training involve the training with using the 15 particular devices you're describing, the vacuum 16 catheters, aspiration catheters? 17 A. Yes. 18 And that's just one way. I mean, there 19 are other tools as well that are available and 20 widely used, such as stent retrievers. 21 (Reporter clarifies.) 22</p>

<p style="text-align: right;">21</p> <p>1 BY MR. MILLER: 2 Q. Are neurovascular surgeries to remove 3 blockage generally considered complex surgeries? 4 <b>A. Yes.</b> 5 Q. How risky are they? 6 MR. STOWELL: Okay. Vague. 7 THE WITNESS: I think, overall, the risk 8 in skilled hands is low. And what I mean by 9 low is the chance of a complication or a 10 significant event is -- you know, it's probably 11 in the 2 to 3 percent range. 12 BY MR. MILLER: 13 Q. But in unskilled hands, it could result 14 in serious injury or death? 15 <b>A. Yes.</b> 16 Q. Do you consider yourself an expert in 17 neurovascular surgery? 18 <b>A. Yes.</b> 19 Q. Do you consider yourself an expert in 20 using aspiration catheters in neurovascular 21 surgeries? 22 <b>A. Yes.</b></p>	<p style="text-align: right;">23</p> <p>1 THE WITNESS: Well, yes. 2 BY MR. MILLER: 3 Q. I think some of them are called, and I 4 might butcher this, venous thromboembolisms; is that 5 right? 6 <b>A. Yes.</b> 7 Q. And I think for short, those are VTEs. 8 <b>A. That just means it occurs on the venous</b> 9 <b>side. That can occur in the brain, it can occur in</b> 10 <b>the periphery, it can occur all over.</b> 11 Q. VTE would include clots like deep vein 12 thrombosis or pulmonary embolisms; right? 13 <b>A. Yes.</b> 14 Q. Do you have experience in treating deep 15 vein thrombosis or pulmonary embolisms? 16 <b>A. No.</b> 17 Q. Are you familiar with techniques to treat 18 them? 19 <b>A. Yes.</b> 20 Q. What is your familiarity with that? 21 <b>A. I mean, obviously, I've read about it a</b> 22 <b>fair bit. I've watched procedures. You know, my</b></p>
<p style="text-align: right;">22</p> <p>1 Q. Do you consider medical training or 2 surgical training and experience to be needed -- to 3 be necessary in being an expert in using aspiration 4 catheters in neurovascular surgeries? 5 MR. STOWELL: Objection. Vague. 6 THE WITNESS: I mean, in today's world, 7 yes. Because, you know, we had to learn -- I 8 mean, you know, the thing is this whole field 9 and this whole technique and strategy has 10 evolved in my lifetime. So we had to figure it 11 out and learn it. 12 But now that that's done, future 13 generations have to -- they'll -- you know, 14 there is no longer that need or that gap in the 15 field that has to be figured out. So, yes, 16 it's important that people learn from current 17 operators and evolve, obviously. 18 BY MR. MILLER: 19 Q. There are other types of clots or 20 embolisms that can occur in the body besides in the 21 brain; right? 22 MR. STOWELL: Objection. Vague.</p>	<p style="text-align: right;">24</p> <p>1 <b>colleagues that are next door to me basically at</b> 2 <b>work, they do the -- they do the peripheral</b> 3 <b>thrombectomies, so to speak. And we specialize in</b> 4 <b>the neurothrombectomies, whether they be venous or</b> 5 <b>arterial.</b> 6 Q. Would you consider yourself an expert in 7 treating deep vein thrombosis or pulmonary 8 embolisms? 9 <b>A. No.</b> 10 Q. Do you know the field of invention of the 11 patents at issue in the IPRs that Imperative has 12 filed against Inari patents? 13 <b>A. No.</b> 14 Q. And just for some education going forward 15 in our conversation, what is an emboli? 16 <b>A. It's a blood clot that travels downstream</b> 17 <b>and blocks off a blood vessel.</b> 18 Q. How about a thrombi? 19 <b>A. A thrombus is a blockage lodged in a</b> 20 <b>blood vessel.</b> 21 Q. So that one doesn't move downstream, it's 22 just stuck?</p>

25

1 **A. Right.**  
2 Q. And is there any difference between the  
3 two in where they are located within the body, or  
4 can they be located anywhere?  
5 **A. They can be anywhere.**  
6 Q. Which one causes an ischemic stroke?  
7 **A. A cerebral.**  
8 Q. A cerebral emboli or thrombi or both?  
9 **A. When it goes to the brain, that's when it**  
10 **causes a stroke, when it blocks off a blood vessel**  
11 **in the brain.**  
12 Q. So when you're trying to treat clots in  
13 the brain, how does the vacuum aspiration catheter  
14 actually remove it? Can you describe that a little  
15 bit?  
16 **A. I'm trying to think about what you're**  
17 **asking me here. The way -- the way I think about**  
18 **it, the way I see it is there's a -- when you --**  
19 **when someone has a stroke, typically it's a blood**  
20 **clot from the heart related to an irregular**  
21 **heartbeat and the person develops blood that is**  
22 **sitting in a place. And blood, when it doesn't move**

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1 in the right ways, it tends to clot itself because  
2 it thinks something is wrong.  
3 So when you build that blood clot, the  
4 majority of blood flow goes to the brain. So the  
5 blood clot is going to travel where blood flow is  
6 the greatest, so it travels to one of the blood  
7 vessels in the brain. It could also go to anywhere  
8 else in the body. And basically that blood clot is  
9 going to travel and stop.  
10 Let me -- the blood vessels in the brain  
11 are like branches in a tree. It starts with one  
12 large trunk and then from there it slowly branches  
13 and tapers and gets smaller and smaller. When that  
14 blood clot reaches a point at which the branch is  
15 smaller than it, it lodges and stops there. And if  
16 it's a larger blood clot, it stops more proximal.  
17 If it's a smaller blood clot, it stops more distal.  
18 The more proximal it is, the larger amount of the  
19 brain that it affects and the bigger the stroke,  
20 meaning the more symptoms somebody will have.  
21 And basically when it comes to aspiration  
22 thrombectomy, the whole goal is you try to get a

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1 catheter that is roughly the size of that blood  
2 clot, hopefully just a hair smaller. It travels  
3 through the blood vessel and you take it to where  
4 the blood clot is. You turn on aspiration. You  
5 see -- if you bought a vacuum cleaner, you always  
6 see where they put tennis balls or something like  
7 that, and they show how it can lift a tennis ball or  
8 pull it over through suction because it has so much,  
9 you know, whatever.  
10 To in my mind, it's similar to that where  
11 the catheter applies a vacuum to that blood clot and  
12 either sucks it through or holds on to it with  
13 greater force than the blood vessel that it's lodged  
14 into has a hold of it. And then you either pull it  
15 out or it sucks through and then you've reopened  
16 that blood vessel.  
17 Q. So when a surgeon is trying to vacuum up  
18 the blood clot for lack of better terms, does the  
19 surgeon build up pressure to apply max pressure to  
20 the clot all at once or is it kind of incremental?  
21 **A. Typically -- typically you do not turn on**  
22 **aspiration on any vacuum until you are engaged with**

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1 the clot. And the -- you know, the main reason for  
2 that -- well, it's -- one, it's what we've always  
3 done; and number two, you know, typically the  
4 catheters that we're using are similar in size to  
5 the blood vessel that we're going into or just  
6 slightly smaller.  
7 And if you turn on the vacuum, the  
8 easiest way to think about it is you are traveling  
9 down a tube, and that tube is essentially a blind  
10 end. In other words, there are branches off of it  
11 at some point. And where that clot is towards where  
12 the catheter is, if you have aspiration going, the  
13 vessel between those two points is going to collapse  
14 and, therefore, you can't traverse it. So you don't  
15 want to have any aspiration force going until you're  
16 engaged with the clot.  
17 Q. And then when you're engaged with the  
18 clot, do you go to maximum vacuum all at once or  
19 maximum pressure or do you --  
20 **A. Yes, we go all at once.**  
21 Q. And why do you do that versus increasing  
22 incrementally?

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1 **A. I mean, the way I kind of think about it**  
2 **is it's kind of like punching. If you -- if you hit**  
3 **somebody with full force, you know, it's going to**  
4 **have a bigger impact than a slow engagement, so to**  
5 **speak. And that's kind of what we've -- again,**  
6 **that's the way we've always done it.**  
7 Q. Are you familiar with the training or  
8 techniques used in treating deep vein thrombosis and  
9 pulmonary embolisms?  
10 **A. To some degree, yes.**  
11 Q. What's your familiarity with the  
12 techniques used to treat those?  
13 **A. In what regard are you asking? I'm not**  
14 **clear what you're --**  
15 Q. Do they also use aspiration catheters in  
16 the treatment of --  
17 **A. Yes.**  
18 (Reporter clarifies.)  
19 BY MR. MILLER:  
20 Q. -- of DVT and PE.  
21 **A. DVT, PEs.**  
22 Q. Would you consider someone an expert on

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1 aspiration catheters for the use of treating VTEs if  
2 they had no medical training or experience in the  
3 medical field?  
4 MR. STOWELL: Objection. Vague.  
5 THE WITNESS: Can you repeat that  
6 question again?  
7 BY MR. MILLER:  
8 Q. Yeah, and maybe I'll rephrase it and make  
9 it clearer.  
10 Would you consider someone an expert on  
11 aspiration catheters for the use in treating DVT and  
12 PE if they had no medical training?  
13 MR. STOWELL: Same objection.  
14 THE WITNESS: It's possible. I mean, you  
15 know, engineers that develop the catheters and  
16 create these devices that have no medical  
17 training. So I mean, there are certainly a lot  
18 of experts in different facets of the industry.  
19 BY MR. MILLER:  
20 Q. And so you would consider an engineer  
21 having experience with designing catheters to be an  
22 expert in -- an expert on vacuum or aspiration

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1 catheters for treating DVT and PE?  
2 **A. They would be an expert on catheter**  
3 **design and construction.**  
4 Q. But not their use in patients?  
5 **A. But not their use in patience.**  
6 Q. And because earlier you said you don't  
7 know the field of invention of the patents at issue  
8 here, you wouldn't know whether that same engineer  
9 would be an expert with respect to the field of  
10 invention of the patents; correct?  
11 **A. Correct.**  
12 Q. Do you know what a person of ordinary  
13 skill is? Do you know the term?  
14 **A. I don't know the term, but I mean, I can**  
15 **infer what it would imply. An average operator**  
16 **would be my guess, but yes.**  
17 Q. Do you know whether you've provided an  
18 opinion in your declaration in these IPRs as to who  
19 a person of ordinary skill is?  
20 **A. I don't know.**  
21 Q. All right.  
22 All right. I'm going to hand you one of

32

1 the declarations you've submitted.  
2 MR. MILLER: So the exhibits are already  
3 premarked as Imperative Care's Exhibit 1022.  
4 BY MR. MILLER:  
5 Q. Do you see on the front page, Dr. Turk,  
6 that it says, in the middle of the page, case  
7 IPR2025-01021?  
8 **A. Yes.**  
9 Q. Do you understand that this -- actually,  
10 do you recognize the document I just put in front of  
11 you?  
12 **A. No, but...**  
13 Q. Do you see that the title of the document  
14 is "Expert Declaration of Aquilla S. Turk, III, D.O.  
15 in Support of Petitions for Inter Partes"?  
16 **A. Yes.**  
17 Q. Taking a look at the last page of the  
18 document, do you recognize that signature?  
19 **A. Yes.**  
20 Q. Is that yours?  
21 **A. Yes.**  
22 Q. Do you understand this to be the

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1 declaration that you submitted in IPR2025-01021?  
2 **A. Yes.**  
3 Q. And as I mentioned earlier, you submitted  
4 declarations in two other IPRs, -01025 and -01264.  
5 Do you recall that?  
6 **A. If you say so.**  
7 Q. Do you know if there are any substantive  
8 differences between your declarations in the three  
9 IPRs?  
10 **A. I don't. But I'm usually pretty**  
11 **consistent, so I would doubt it.**  
12 Q. When you were preparing this declaration,  
13 did you review the patents at issue in the IPRs?  
14 **A. I don't know, but I seriously doubt it.**  
15 **I don't typically review patents, it's not my -- my**  
16 **area of strength.**  
17 Q. Do you know whether you reviewed U.S.  
18 Patent Number 11,969,333?  
19 **A. I'm sure I did not.**  
20 Q. Do you know whether you reviewed U.S.  
21 Patent Number 12,016,580?  
22 **A. Again, I seriously doubt it.**

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1 Q. Same answer for U.S. Patent 11,974,910?  
2 **A. Yes.**  
3 Q. Is it fair to say since you didn't read  
4 the patents, you didn't analyze or read the claims  
5 of those patents?  
6 **A. Correct.**  
7 Q. Your declaration doesn't provide an  
8 opinion regarding what is set forth in the patents;  
9 right?  
10 MR. STOWELL: Objection. Vague.  
11 THE WITNESS: I'm not sure what "set  
12 forth in the patent" means.  
13 BY MR. MILLER:  
14 Q. Let me rephrase.  
15 Your declaration doesn't provide an  
16 opinion regarding what you believe the patents to  
17 encompass; correct?  
18 **A. Correct.**  
19 Q. And while your declaration might discuss  
20 some techniques for treating certain types of clots  
21 and maybe your disagreement with Inari's  
22 characterization of certain techniques or devices,

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1 you didn't actually analyze or apply prior art to  
2 the claims of the patents; right?  
3 **A. Correct.**  
4 Q. So to be clear, you didn't render an  
5 opinion regarding the patentability of the patents;  
6 correct?  
7 **A. Correct.**  
8 **Makes me think of Star Trek. Dammit,**  
9 **Jim, I'm just a doctor.**  
10 Q. It's a good reference.  
11 Can we go to the second page of the  
12 document of your declarations. It's titled Table of  
13 Exhibits.  
14 **A. Okay.**  
15 Q. Do you see that it goes on for like four  
16 pages?  
17 Taking a look at this table, do you know  
18 what documents you did review in preparing your  
19 declaration?  
20 **A. No.**  
21 Q. Is it fair to say that even if a document  
22 is listed on this, you didn't necessarily read it?

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1 **A. Yes.**  
2 Q. So if we go further into your  
3 declaration -- actually, maybe you can look at the  
4 first page. And you can feel free to skim through  
5 the document if you would like.  
6 Your declaration does not provide a legal  
7 standards section; correct?  
8 **A. If you say so. I don't know what a legal**  
9 **standards declaration is.**  
10 Q. So your -- your declaration doesn't  
11 describe what standards of the law you applied in  
12 reaching your opinions as set forth in your  
13 declaration; correct?  
14 **A. I don't think so.**  
15 Q. Were you informed of what legal standards  
16 you should be adhering to in providing your  
17 opinions?  
18 **A. No, I don't -- I think it was just -- as**  
19 **far as I know, I don't know that there are legal**  
20 **standards that I get arrested if I say this or don't**  
21 **say that. As far as I know, I'm just giving my**  
22 **expert opinion on strokes, thrombectomies,**

<p style="text-align: right;">37</p> <p><b>1 aspiration, those topics.</b></p> <p>2 Q. Your declaration -- actually, strike</p> <p>3 that.</p> <p>4 You do not discuss -- are you familiar</p> <p>5 with the term "obviousness"?</p> <p>6 MR. STOWELL: Objection. Vague.</p> <p>7 THE WITNESS: I mean, I know what obvious</p> <p>8 is. But...</p> <p>9 BY MR. MILLER:</p> <p>10 Q. With respect to patent law?</p> <p><b>11 A. No.</b></p> <p>12 Q. Are you familiar with the term</p> <p>13 "anticipation" with respect to patent law?</p> <p><b>14 A. No.</b></p> <p>15 Q. Is it fair to say that your declaration</p> <p>16 doesn't address obviousness or anticipation?</p> <p>17 MR. STOWELL: Objection. Vague.</p> <p>18 THE WITNESS: I do not know the answer to</p> <p>19 that. I mean, it -- I would assume a lawyer</p> <p>20 could make my document appear in some way,</p> <p>21 whatever term it is you want to be. But</p> <p>22 that's...</p>	<p style="text-align: right;">39</p> <p>1 years and during my lifetime.</p> <p>2 What I mean by that is, you know, when I</p> <p>3 started doing this in the early 2000s, we</p> <p>4 typically would take devices used in cardiology</p> <p>5 and for cardiovascular surgeries and apply them</p> <p>6 to -- to our areas because the blood vessel</p> <p>7 sizes were similar. So the catheters, whether</p> <p>8 they be stents, whether they be balloons,</p> <p>9 whether they be catheters, whether they be any</p> <p>10 tool were similar sized, so we could apply them</p> <p>11 for our uses if we could get them there.</p> <p>12 And that's kind of what this is saying,</p> <p>13 is that catheters originally used in the heart</p> <p>14 were then applied to other parts of the body.</p> <p>15 And that's still kind of typically done today</p> <p>16 because the cardiac -- the cardiovascular world</p> <p>17 is, you know, several years ahead</p> <p>18 technology-wise than the neuro spaces, than the</p> <p>19 peripheral spaces. So we often have to -- or</p> <p>20 we often can apply tools or techniques from</p> <p>21 that over to our areas.</p> <p>22</p>
<p style="text-align: right;">38</p> <p>1 BY MR. MILLER:</p> <p>2 Q. You stated earlier that you didn't render</p> <p>3 an opinion regarding the patentability of the</p> <p>4 patents; is that fair to say?</p> <p><b>5 A. Correct.</b></p> <p>6 Q. So if we take a look at Section 4 of your</p> <p>7 declaration that's on page 12, you see it's titled</p> <p>8 "Catheters develop -- Catheter Developers Routinely</p> <p>9 Adapt Catheters For Use in Other Parts of the</p> <p>10 Vasculature."</p> <p>11 Do you see that?</p> <p><b>12 A. Okay.</b></p> <p>13 Q. What does this section describe?</p> <p>14 MR. STOWELL: Objection. Vague.</p> <p>15 Document speaks for itself.</p> <p>16 THE WITNESS: I mean, I can take the time</p> <p>17 to read it all. But at least reading the</p> <p>18 beginning of it, what it seems to me to be</p> <p>19 talking about is -- relates a little bit to</p> <p>20 what we were talking about earlier with the</p> <p>21 evolution of techniques and methods and tools</p> <p>22 to treat strokes, you know, evolved over the</p>	<p style="text-align: right;">40</p> <p>1 BY MR. MILLER:</p> <p>2 Q. In your role as a neurovascular surgeon</p> <p>3 or as the chief medical officer of Imperative, have</p> <p>4 you been involved in the actual designing of</p> <p>5 aspiration catheters?</p> <p>6 MR. STOWELL: Objection. Vague.</p> <p>7 THE WITNESS: I'm not sure how to answer</p> <p>8 that except that I basically for my entire</p> <p>9 career, whether it be Imperative Care or other</p> <p>10 companies that I have consulted for, I have</p> <p>11 routinely given -- or I should -- given</p> <p>12 feedback, worked extensively with various</p> <p>13 engineers to help them improve their devices.</p> <p>14 In other words, we often will work with</p> <p>15 engineers in various companies of -- this</p> <p>16 catheter needs more support in this area, needs</p> <p>17 more flexibility in this area in order to</p> <p>18 perform better.</p> <p>19 Am I on a patent? No. Am I in there</p> <p>20 choosing the materials and choosing how to</p> <p>21 strategically make it a better device? No.</p> <p>22 But as far as performance and giving</p>

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1 suggestions as to how to improve it, yes, I  
2 have helped in that way.  
3 Not sure if that answers your question,  
4 but that's all I got.  
5 BY MR. MILLER:  
6 Q. So if we turn to paragraph 26, that first  
7 paragraph in Section 4 -- actually, before I ask  
8 that...  
9 Do you know what prior art with respect  
10 to patent law is?  
11 **A. I mean, I would assume it would be**  
12 **somebody describing or drawing out that design on**  
13 **a -- on a prior patent that somebody else -- than**  
14 **whatever it is you're using.**  
15 Q. Are you aware of whether -- strike that.  
16 Did you provide any opinion in Section 4  
17 with respect to whether any of the articles or  
18 aspiration catheters you described are prior art to  
19 the patents at issue in this case?  
20 MR. STOWELL: Objection. Vague.  
21 Document speaks for itself.  
22 THE WITNESS: I don't think I did.

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1 BY MR. MILLER:  
2 Q. Okay. Let's look at paragraph 26.  
3 **A. Patents aren't really -- it's not my area**  
4 **of expertise. So I seriously doubt I gave any**  
5 **opinions on patent to anything.**  
6 Q. So looking at paragraph 26, you describe  
7 an article from the American Journal of Cardiology  
8 published in 1993.  
9 Do you see that?  
10 **A. Yes.**  
11 Q. In there you state that they used an  
12 aspiration catheter to remove blood clots from the  
13 left main coronary -- coronary artery or the right  
14 coronary artery of five patients.  
15 Do you see that?  
16 **A. Yes.**  
17 Q. And you conclude that "This basic  
18 aspiration procedure is not significantly different  
19 from the aspiration procedures used today to extract  
20 clots from the brain, legs and lungs."  
21 Do you see that?  
22 **A. Yes.**

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1 Q. In this paragraph, you don't describe the  
2 changes made to aspiration catheters from 1993 to  
3 today; correct?  
4 **A. Correct.**  
5 **So an aspiration catheter is an**  
6 **aspiration catheter. There is nothing novel or new**  
7 **or interesting about it. It's a dumb tube. Okay?**  
8 **The easiest way to think about it is a straw. Okay?**  
9 **There's nothing magical in its powers.**  
10 **What's changed with aspiration catheters**  
11 **is construction methods and materials that allow**  
12 **them to track through certain anatomies or to more**  
13 **easily get to a destination through that anatomy.**  
14 **But when it comes to performing an**  
15 **aspiration thrombectomy to remove the blood -- in**  
16 **other words, apply aspiration to remove the blood**  
17 **clot, it -- it's all the same. It's just a tube and**  
18 **what's changed and improved is the construction of**  
19 **it to allow it to navigate through the anatomies to**  
20 **get there.**  
21 **But, you know, whether that's a very**  
22 **stiff crude tool from 1993 or whether it's a new**

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1 **slick new tool from 2040 that we'll make in the**  
2 **future, unless we develop a new way to apply that or**  
3 **a new way is come up with to construct these**  
4 **catheters, it's simply applying suction to the end.**  
5 **And does it work or does it not.**  
6 Q. Is it fair to say there are various  
7 techniques or I guess more than one technique for  
8 ensuring, you know, no leakage of the valve?  
9 MR. STOWELL: Objection. Vague. Lack of  
10 foundation.  
11 THE WITNESS: I'm not sure what you're  
12 asking me. Leakage of what -- I mean...  
13 BY MR. MILLER:  
14 Q. So --  
15 **A. There's not a valve. I mean, maybe --**  
16 **maybe a certain system has a valve in it that could**  
17 **leak, sure.**  
18 Q. Uh-huh.  
19 **A. But as a -- for sure something like this,**  
20 **where you take a catheter and have a syringe,**  
21 **there's no valve there. So I'm not sure what you're**  
22 **asking me here in this question.**

<p style="text-align: right;">45</p> <p>1 Q. There are multiple ways to create 2 suction. So one way is a syringe; right? 3 <b>A. Sure.</b> 4 Q. What are some other ways you're familiar 5 with to create the suction to aspirate the clot? 6 <b>A. Yeah, I mean, it's typically a syringe or 7 it's a pump.</b> 8 Q. So looking at paragraph 27, you describe 9 another system, the Penumbra? 10 <b>A. P-E-N-U-M-B-R-A.</b> 11 Q. And that was from the late 2000s? 12 <b>A. Yes.</b> 13 Q. And you describe it as using a guide 14 catheter inserted through the patient's vasculature 15 to a position near the clot. 16 Do you see that? 17 <b>A. Yes.</b> 18 Q. And you say you were an early adopter of 19 the Penumbra System and you used it often? 20 <b>A. Yes.</b> 21 Q. Do you recall using that device? 22 <b>A. Yes.</b></p>	<p style="text-align: right;">47</p> <p>1 <b>work, then try other techniques such as a stent 2 retrieve or a balloon or some other tool.</b> 3 <b>And we named it that because ten-plus 4 years ago when we came up with it, this was – 5 nobody knew about it. Everybody was using stent 6 retrievers or other tools that were around at that 7 time.</b> 8 Q. We also like really cool acronyms. 9 <b>A. True.</b> 10 Q. And you described it as including "a very 11 large, easily trackable, aspiration thrombectomy 12 catheters that can now more easily and reliably 13 navigate cerebrovasculature." 14 Do you see that? 15 <b>A. Yes.</b> 16 Q. And you say that "These new catheters 17 allowed surgeons to traverse very tortuous blood 18 vessels, such as those found in the brain, and reach 19 more remote locations." 20 Do you see that? 21 <b>A. Yes.</b> 22 Q. In paragraph 28, you don't describe what</p>
<p style="text-align: right;">46</p> <p>1 Q. How is that device different than the 2 device you described in 1993? 3 <b>A. The catheters are more -- are more 4 purpose built. In other words, they -- they're 5 designed to navigate through the tortuosity of the 6 carotid siphon meaning the blood vessels in the 7 skull base to be able to then access the blood 8 vessels in the brain.</b> 9 Q. Neither in paragraph 26 or 7 do you 10 describe what modifications would be needed to use 11 those aspiration catheters for the treatment of DVT 12 or PE; right? 13 <b>A. No.</b> 14 Q. Next in paragraph 28, you cite a 2014 15 article describing "ADAPT." 16 What is ADAPT? 17 <b>A. Adapt is basically the name we gave 18 aspiration thrombectomy. And it stands for A Direct 19 Aspiration First Pass Technique. And what that 20 basically means is use aspiration as your first 21 approach, meaning when you go up to open up the 22 blood vessel, try aspiration first. If that doesn't</b></p>	<p style="text-align: right;">48</p> <p>1 modifications would be needed to those catheters to 2 be used to treat DVT or PE; right? 3 MR. STOWELL: Objection. Lack of 4 foundation. 5 THE WITNESS: Correct. 6 BY MR. MILLER: 7 Q. And so then in paragraph 29, you say 8 that, "The advances were not restricted to 9 neurovascular aspiration catheters, but extended to 10 aspiration catheters for treating PE and DVT." 11 Do you see that? 12 <b>A. Yes.</b> 13 Q. And you say, "Medical device companies 14 routinely adapt procedures and components initially 15 developed for one medical procedure for another." 16 Do you see that? 17 <b>A. Yes.</b> 18 Q. You didn't provide any examples in that 19 paragraph; correct? 20 <b>A. It does not appear so.</b> 21 Q. And you didn't describe the modifications 22 needed to the aspiration catheters to treat PE and</p>

<p style="text-align: right;">49</p> <p>1 DVT; correct? 2 MR. STOWELL: Objection. Lack of 3 foundation. 4 THE WITNESS: Correct. I think I did 5 that somewhere else, though. I'm not sure 6 where, but I do recall that we talked about 7 that at some point. Because the examples for 8 that would be Penumbra, taking their aspiration 9 catheters for the brain and making them a 10 little bit bigger and reinforcing in some areas 11 and -- to make them applicable for PE or DVT or 12 peripheral thrombectomy meaning legs, arms, 13 that kind of thing. Mostly legs, but... 14 BY MR. MILLER: 15 Q. And I think you do describe that in 16 paragraph 30, the very next paragraph. And I think 17 on the next page, page 15, you state, "Once Penumbra 18 developed an effective device for neurovascular 19 applications, Penumbra upsized its device" -- 20 <b>A. I knew you'd get to it.</b> 21 Q. -- "for use in the lungs and peripheral 22 vasculature."</p>	<p style="text-align: right;">51</p> <p>1 <b>aspiration force.</b> 2 Q. And then, actually, going back to 3 paragraph 30 for a second, besides the upsizing of 4 its device for use in the lungs and peripheral 5 vasculature, you don't describe any other 6 modifications needed to use the Penumbra device in 7 treating PE and DVT, do you? 8 <b>A. No, but we just talked about that in that</b> 9 <b>they -- you know, aside from size, which they'll</b> 10 <b>optimize the size, it's also a matter of reinforcing</b> 11 <b>in some areas so it gives better support and</b> 12 <b>trackability through the vascular anatomy.</b> 13 Q. Do you describe that in this paragraph? 14 <b>A. Somewhere in there we did because we</b> 15 <b>talked about how if the catheter can -- catheters</b> 16 <b>that can track -- it's difficult to make catheters</b> 17 <b>softer and more trackable. It's a lot easier to</b> 18 <b>make them stiffer and more supportive.</b> 19 <b>So it is -- in general, if a -- if a</b> 20 <b>device treats a stroke, it's easy to go the other</b> 21 <b>way. The stroke is the hardest thrombectomy</b> 22 <b>procedure, in my opinion, out there and requires the</b></p>
<p style="text-align: right;">50</p> <p>1 <b>A. Yep.</b> 2 Q. You didn't describe -- you say they 3 upsized. You didn't include any examples or cites 4 to the exact modifications that were made; right? 5 <b>A. Correct.</b> 6 Q. In paragraph 31, you describe 7 Imperative Care's own aspiration catheters; correct? 8 <b>A. Sorry, repeat that question.</b> 9 Q. So in paragraph 31, you begin referring 10 to Imperative Care's own aspiration catheters; 11 correct? 12 <b>A. Yes.</b> 13 Q. And you say that, "Imperative Care's 14 neuro pump is also used with its products for 15 peripheral vascular"; correct? 16 <b>A. Yes.</b> 17 Q. Are those neuro pumps able to be used 18 without any modification for the use in peripheral 19 vasculature? 20 <b>A. I -- I'm not positive, but I think so.</b> 21 <b>And I mean, a pump is a pump. It's not doing</b> 22 <b>anything magical. It's just simply applying vacuum</b></p>	<p style="text-align: right;">52</p> <p>1 <b>most sophisticated devices.</b> 2 <b>If you want to make it more supportive</b> 3 <b>and stiffer, that's a relatively easy change to a</b> 4 <b>device. And accessing and reaching a pulmonary</b> 5 <b>embolus is much more straightforward than reaching a</b> 6 <b>brain embolus, just anatomy-wise.</b> 7 Q. Besides making it bigger, more supportive 8 and stiffer, are there any other modifications 9 you've described in your declaration that someone 10 would need to make to a neurovascular aspiration 11 catheter to use to treat PE and DVT? 12 <b>A. I mean, I'm sure there are lots of things</b> 13 <b>that could be done, but I don't think anything would</b> 14 <b>necessarily have to be done. You know, an engineer</b> 15 <b>may want to change the inner liner, they may want to</b> 16 <b>change, you know, what type of plastic or extrusion</b> 17 <b>they use in the catheter design to make it easier to</b> 18 <b>manufacture. You know, there are all kinds of, you</b> 19 <b>know, engineering things that can be done or need to</b> 20 <b>be done, but nothing necessarily has to be done to</b> 21 <b>apply from one area to another.</b> 22 <b>And again, that all goes -- boils down in</b></p>

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1 my mind to the basic tenants of aspiration  
2 thrombectomy, which is, if you got a big clot, you  
3 need a big catheter. That's really what it comes  
4 down to.  
5 Q. Do you agree that neurovascular  
6 aspiration is the same field or discipline as the  
7 aspiration of clots for like PE and DVT?  
8 MR. STOWELL: Objection. Vague.  
9 THE WITNESS: The same field. What --  
10 what are you implying?  
11 BY MR. MILLER:  
12 Q. Do you consider it the same -- like the  
13 same practice, same medical practice?  
14 A. The tools are very similar, the concepts  
15 overlap. The basic tenants are the same. The  
16 doctors tend to be different. You know, for PE,  
17 DVT, they tend to be done by vascular surgeons,  
18 interventional radiologists, some cardiologists.  
19 Stroke, some interventional radiologists do those.  
20 And there are a handful of guys out there that do  
21 both. But stroke tends to be done by neuro doctors,  
22 not by heart doctors or vascular surgeons.

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1 So, I mean, the field, so to speak, is  
2 different, but the basic tenants, the basic  
3 concepts, I think, are very similar. There are  
4 certainly technique adaptations that may differ,  
5 which, again, to me, it's a mat -- you know, relates  
6 to different -- you know, you're taking the blood  
7 clot out, and you are doing a thrombectomy, you're  
8 using aspiration and all the things are the same.  
9 Your techniques may just differ a little bit based  
10 on the anatomy and what -- what it is you're dealing  
11 with.  
12 Q. What do you mean with respect to the  
13 adaptations may differ, I think you said, because  
14 it's different --  
15 A. Yeah, for instance, going -- going and  
16 applying aspiration to a clot to remove it, we're  
17 all doing that exact same thing. When it comes to  
18 how do you do it and how do you make it work best,  
19 that's what you need to figure out. That's the  
20 technique that the doctors have to figure out.  
21 What we found for aspiration for the  
22 brain is that if you go in and put the catheter near

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1 the clot, it's going to suck the vessel down and  
2 you're not going to get the clot. If you put it  
3 into the clot, you'll get it almost every time.  
4 In peripheral throm- -- in treating PE,  
5 what we found for siphoning is if we take our  
6 catheter and put it at the face of the clot, it will  
7 slowly get it out, but it takes a lot of work and  
8 effort. We found that if we bury it in the clot and  
9 do a step-wise aspiration, where we aspirate, stop,  
10 and pull it back a little bit, aspirate and stop,  
11 pull it back a little bit, and work our way  
12 backwards back through the clot, it gets it out very  
13 quickly and very effectively with minimal blood  
14 loss.  
15 So, again, it's just how do you apply  
16 your tool using the exact same, again, just  
17 aspiration. But how do you apply that to that  
18 anatomy.  
19 Q. We've been going for a little over an  
20 hour. Why don't we take a five-, ten-minute break?  
21 MR. STOWELL: Okay.  
22 THE VIDEOGRAPHER: The time now is

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1 9:20 a.m. We are now off the record.  
2 (A brief recess was taken.)  
3 THE VIDEOGRAPHER: We are now back on the  
4 video record. The time now is 9:31 a.m.  
5 Counsel, you may proceed.  
6 BY MR. MILLER:  
7 Q. In paragraph 33, you say treating blood  
8 clots in the brain is much more difficult than  
9 treating blood clots in the lungs and peripheral  
10 arteries for several reasons.  
11 Do you see that?  
12 A. Yes.  
13 Q. And you go on in the next two paragraphs  
14 or several paragraphs to explain why.  
15 A. Yes.  
16 Q. Can -- you know, you can either look at  
17 those paragraphs or just tell me why is it more  
18 difficult to treat blood clots in the brain?  
19 A. Yeah, I mean -- no, I mean, I think -- I  
20 think -- I don't think I can lay it out any better  
21 than did I here, actually. I kind of like it.  
22 Do you want me to read this off or --

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1 Q. No, it's fine, we can walk through it.  
2 Then.  
3 So you say in paragraph 34 that the  
4 catheter is used to extract cerebral blood -- blood  
5 clots typically traverse a longer distance than the  
6 catheters used in the peripheral arteries.  
7 Do you see that?  
8 **A. Yes.**  
9 Q. And is the length the reason why it's  
10 more complicated?  
11 **A. I mean, the longer you -- the longer**  
12 **catheters are, the more -- the less responsive they**  
13 **typically tend to be. So the closer you can be, the**  
14 **easier it is to typically control and for the**  
15 **catheters to perform and behave and navigate and**  
16 **whatever term you want to put on it.**  
17 **And also for aspiration force as well,**  
18 **the shorter the distance, the better you are at**  
19 **aspirating.**  
20 Q. Why are they less responsive, and what  
21 does that mean?  
22 **A. I mean, it's kind of like a stick. You**

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1 **know, if you have a long stick, it's -- it's more**  
2 **difficult to control than a short stick. But the**  
3 **real -- the real -- the real challenges are the --**  
4 **the tortuosity that we have to navigate through in**  
5 **the blood vessels in the brain, as well as the**  
6 **delicate nature of them since, you know, they are**  
7 **not -- you know, they're floating, so to speak, on**  
8 **the surface of the brain and you're having to**  
9 **navigate that. And the anatomy changes. You**  
10 **straighten out, curves, things like that.**  
11 Q. Right.  
12 So in paragraph 35 you state, "The  
13 catheters for treating cerebral occlusions must  
14 navigate blood vessels that are often more tortuous  
15 than the vessels encountered in the lungs and  
16 peripheral vasculature"; Right?  
17 **A. Yes.**  
18 Q. What is tortuosity?  
19 **A. I mean, I guess what I would say is it**  
20 **has to do with the redundancy of the curve, the**  
21 **angle of the curves and curves of the blood vessels**  
22 **themselves. It's like -- what is that street in**

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1 **San Francisco? Lombard Street or something like**  
2 **that. You know, you get a lot of very acute and**  
3 **redundant turns that you have to navigate through.**  
4 Q. And those acute angles are more  
5 pronounced in the brain?  
6 **A. Yes.**  
7 Q. And in paragraph 36 you state, "The  
8 cerebral arteries are more delicate than the  
9 peripheral vasculature because they lack a robust  
10 muscularis layer and must rely on the  
11 adventitial" --  
12 **A. Adventitial.**  
13 Q. "-- adventitial layer for their  
14 durability"; right?  
15 **A. Yes.**  
16 Q. Is that --  
17 **A. What that -- what that means -- the**  
18 **implications or the importance of that is that the**  
19 **ability to damage or perforate or, you know, injure**  
20 **that blood vessel is much easier than arteries in**  
21 **other parts of the body.**  
22 Q. Is it fair to say, then, with respect to

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1 cerebral arteries, the amount of pressure you're  
2 applying using the aspiration catheter is  
3 important -- is important to control?  
4 **A. No. No, because you're not applying**  
5 **pressure to the vessel. You're applying that**  
6 **pressure to the clot. And that's -- but that's also**  
7 **why as the catheter size approaches the blood vessel**  
8 **size, there's not a lot of space around it with**  
9 **blood. But that's also why these blood vessels, if**  
10 **you're not in the clot and you apply aspiration, it**  
11 **just collapses the blood vessel.**  
12 Q. And that would be bad?  
13 **A. Well, I mean, it's not good. But you're**  
14 **not going to hurt the person from that.**  
15 **What I'm saying by the delicate nature of**  
16 **the blood vessel is these catheters have to be**  
17 **pretty supple or else if they're -- or else they**  
18 **could perforate through the blood vessel and burst**  
19 **it, which would likely be a fatal event.**  
20 **You know, the -- the aspiration, that's a**  
21 **whole different side of the equation. That's**  
22 **more -- that's you interacting with the blood clot**

<p style="text-align: right;">61</p> <p><b>1 to remove the blood clot.</b> 2 Q. Okay. And so folks sitting on the 3 aspiration side of the equation, what are like -- 4 what are -- what are factors you have to take into 5 consideration when aspirating the blood clot with 6 respect to, you know, the safety of the patient? 7 MR. STOWELL: Objection. Vague. 8 THE WITNESS: Yeah, I mean, it's -- with 9 aspirating the clot, you're not going to hurt 10 the patient by turning on aspiration. I could 11 go -- I could take an aspiration catheter and 12 put it in any blood vessel and turn on 13 aspiration and it's not going to really do 14 anything. 15 Where you -- what you need for doing a -- 16 doing a stroke thrombectomy or using these 17 catheters in the brain is you've got to have a 18 catheter that's soft enough and supple enough 19 to be able to navigate these curves and be able 20 to safely traverse these blood vessels in the 21 brain and apply aspiration without collapsing 22 the catheter.</p>	<p style="text-align: right;">63</p> <p><b>1 every procedure we have done in the brain, we</b> <b>2 telescope, is what you call it. But we have a</b> <b>3 stiffer guide catheter here, and it may even be two</b> <b>4 or three sizes bigger than what we need for the</b> <b>5 surgery so we can have another softer catheter</b> <b>6 inside of that, so we can then take our devices</b> <b>7 through this other catheter to do whatever job we</b> <b>8 need to do.</b> 9 Q. And at the end of paragraph 36, you say, 10 "A perforation or tear out of the cerebral 11 vasculature would be devastating for the patient." <b>12 A. Yes.</b> 13 Q. Could that include that? <b>14 A. Yes. Hopefully it does. Because that's</b> <b>15 often preferred by people over the alternative,</b> <b>16 which is severely impaired.</b> 17 Q. Is it fair to say that your opinion in 18 paragraph 37 is that given the complexity of neuro 19 vasculature treatments using aspiration catheters, 20 that treating PE and DVT is simpler and so it, in 21 your view, makes sense to go from more complex to 22 simple?</p>
<p style="text-align: right;">62</p> <p>1 Whereas in the periphery or in the lungs, 2 you don't have nearly the curves and the 3 tortuosity that you have to get through. And 4 that's why we tend to -- you know, we've got a 5 guide catheter that is in the base of the skull 6 or something that is relatively stiff. And for 7 sure you wouldn't use in the head because you 8 would easily perforate or rupture or cause a 9 problem. 10 So we tend to put in a stiff catheter for 11 support to then be able to take these smaller 12 catheters inside of it that can navigate 13 through the tortuosity and get out to -- safely 14 into the blood vessels in the brain. 15 BY MR. MILLER: 16 Q. So you perfectly predicted my next 17 question. 18 So if someone were to use a stiffer, less 19 flexible and larger catheter in the brain, it could 20 cause serious harm? <b>21 A. Yeah, yes, sir.</b> <b>22 But that's why we -- and with basically</b></p>	<p style="text-align: right;">64</p> <p>1 MR. STOWELL: Objection. Vague. 2 Document speaks for itself. 3 THE WITNESS: I am not sure what you're 4 asking me. 5 BY MR. MILLER: 6 Q. It was a bad question. 7 So you say -- in the middle of the 8 paragraph, 37, you say "Given all of these 9 challenges, it's not surprising that surgeons could 10 readily transfer the cerebral technology to simpler 11 applications, like the lungs and peripheral 12 vasculature." 13 Do you see that? <b>14 A. Uh-huh. So what I mean by that is that,</b> <b>15 number 1, when it comes to stroke, time is of the</b> <b>16 essence, which for -- for DVT, it's not of the</b> <b>17 essence, necessarily. In other words, every minute</b> <b>18 doesn't count. For PE, only the most extreme</b> <b>19 cases -- I mean, there are cases where patients are</b> <b>20 trying to die on your table with PE as well, but</b> <b>21 every stroke case, every minute matters on every</b> <b>22 patient.</b></p>

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1 So -- so I think that, you know, if  
2 you're going to have a successful tool and/or  
3 technique it has to be something that is very  
4 efficient and very fast because of the time  
5 implications.  
6 In addition, as we've mentioned before  
7 earlier, the ability to navigate into the cerebral  
8 vessels takes the most sophistication of the  
9 catheter on the design level. And what I mean by  
10 that is it's -- it's -- from my -- in talking to a  
11 lot of engineers, it's much easier to take a -- to  
12 make a catheter more supportive and more stiffer and  
13 make it bigger. It's usually harder to make it more  
14 navigable and more softer and flexible and smaller.  
15 So because of that it's easier to go  
16 backwards than to go forwards. Meaning -- and what  
17 I mean by backward and forward is to go stroke, to  
18 going into the peripheral and pulmonary spaces.  
19 Q. So in paragraph 37, although that is your  
20 conclusion, and with respect to the other paragraphs  
21 of Section 4, you don't explain the modifications  
22 that would be needed to make the prior art asserted

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1 in this IPR read on the claims of the patents at  
2 issue; right?  
3 **A. Right. I'm not going to give you the**  
4 **secret sauce.**  
5 Q. So you're just speaking in this section  
6 more general --  
7 **A. In generalities, yes. Yes, I'm not a**  
8 **patent expert.**  
9 Q. So if we turn to Section 5 on  
10 paragraph -- on page 18 of your declaration, it's  
11 titled "Blood clots vary as do the catheters used to  
12 treat them."  
13 Do you see that?  
14 **A. Yes.**  
15 Q. And this first paragraph has some  
16 disagreement over description or distinction between  
17 clots. You say regardless -- at the end of it you  
18 conclude, "Regardless of clot type, aspiration  
19 thrombectomy involves aspirating the clot into the  
20 catheter."  
21 Do you see that?  
22 **A. Uh-huh.**

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1 Q. Is your view that it doesn't really  
2 matter what the type of clot is, it's going to be  
3 the same technologies to get rid of it?  
4 **A. I mean, there are different types of**  
5 **clots. There are clots that are very organized,**  
6 **there are clots that are very unorganized, and**  
7 **aspiration does a good job on all clot types is how**  
8 **I would say it. And there are some histologic**  
9 **studies that have been done that have shown -- that**  
10 **have shown that, you know, in the neuro space for**  
11 **sure.**  
12 **But, I guess, I mean, I'm not sure I**  
13 **answered your question, but...**  
14 **But there are different clot compositions**  
15 **and aspiration works very well on all clot**  
16 **compositions.**  
17 Q. So in paragraph 39 you go on to state  
18 that you don't agree with the position that  
19 cerebral -- or aspiration catheters used for  
20 cerebral vasculature are much smaller than  
21 aspiration catheters used for lungs and peripheral  
22 vasculature. But I thought we were just talking

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1 about how if you don't use a smaller catheter, you  
2 can, like, cause perforation in the cerebral  
3 vasculature.  
4 So I'm just trying to understand the  
5 distinction you're drawing in this paragraph.  
6 **A. Yeah, I mean, is it -- again, to me, it's**  
7 **basic tenants of aspiration. In general, the larger**  
8 **the blood clot or the blood clot burden, the larger**  
9 **the catheter size that you want to use.**  
10 **When you look at -- when you look at**  
11 **catheter sizes that are out there, there's**  
12 **definitely overlap between what we use in the brain**  
13 **and what's used in the lungs and the periphery. You**  
14 **know, we -- typically, the largest one we will use**  
15 **in the head and neck are 8 French and in the -- in**  
16 **the periphery arterial-wise, they tend to be similar**  
17 **in the 5 to 8 French or so. In the venous space,**  
18 **they tend to go bigger because, again, the tubes, so**  
19 **to speak, the vessels are bigger.**  
20 **And on that note, you know, if we have**  
21 **venous thrombosis in the brain, we will oftentimes**  
22 **use the peripheral system from Penumbra in that area**

<p style="text-align: right;">69</p> <p>1 <b>because the size is bigger.</b> 2 <b>So, again, to me, it's really more about</b> 3 <b>vessel size matching more so in that regard. But,</b> 4 <b>again, in general, the brain blood vessels are on</b> 5 <b>the smaller end compared to other areas, so it's</b> 6 <b>really more about size.</b> 7 Q. Turning back just for a moment to the 8 table of exhibits on -- look on the first page. 9 Did you, in preparing your declaration, 10 read Exhibit Numbers 1005, 1006, or 1012? 11 <b>A. No.</b> 12 Q. In your experience -- actually, strike 13 that. 14 I don't know if I asked this direct 15 question earlier. Have you actually aspirated a PE 16 or DVT before? 17 <b>A. No.</b> 18 Q. Have you been in the room for one of 19 those procedures? 20 <b>A. Yes.</b> 21 Q. How many times would you say? 22 <b>A. I mean, I've been around, watched, you</b></p>	<p style="text-align: right;">71</p> <p>1 aspiration catheters in the past and present is the 2 material changes that they've made and the sizes and 3 shapes of them? 4 <b>A. I mean, the only -- the only novel thing</b> 5 <b>out -- the only novel change that's really occurred</b> 6 <b>has been the new Imperative Care catheters. When I</b> 7 <b>say "new," I mean the Imperative Care catheters in</b> 8 <b>that we now have a beveled tip. So in other words,</b> 9 <b>instead of the catheter being a tube, think of it</b> 10 <b>like a straw with a regular end. We have a beveled,</b> 11 <b>we have an angled tip on ours.</b> 12 <b>So think of it like when you order a</b> 13 <b>drink with like Boba, if you have ever seen those,</b> 14 <b>the straw has like a bevel at the end to get those</b> 15 <b>little pieces in better. We felt like the angle on</b> 16 <b>the tip gives us an advantage in getting the clot</b> 17 <b>out over a conventional just bare end.</b> 18 <b>That's really the only change that I've</b> 19 <b>seen or difference in any other catheters that are</b> 20 <b>commercially available, of all of the catheters that</b> 21 <b>are out there commercially available.</b> 22 (Reporter clarifies.)</p>
<p style="text-align: right;">70</p> <p>1 <b>know, eight or nine at least. I'm not frequently in</b> 2 <b>the room. I'm usually more in the control room, but</b> 3 <b>it's right -- you know, still me to you away</b> 4 <b>(indicating).</b> 5 Q. In those instances where you were 6 involved in the procedure one way or another, did 7 you know what type of aspiration catheter they were 8 using? 9 <b>A. Yes.</b> 10 Q. Do you recall what types those were or 11 what brands? 12 <b>A. I mean, I've seen them use Penumbra, I've</b> 13 <b>seen them use Inari, I've seen them use Imperative.</b> 14 <b>And then there's another, I think it was Pounce, or</b> 15 <b>something like that.</b> 16 (Reporter clarifies.) 17 THE WITNESS: P-O-U-N-C-E. Some other 18 startup, something or another. And I may be 19 wrong on that name. 20 BY MR. MILLER: 21 Q. Is it your view or is it your opinion 22 that the only substantial differences between</p>	<p style="text-align: right;">72</p> <p>1 BY MR. MILLER: 2 Q. So if we look -- sorry if I'm going out 3 of order in your declaration. 4 So if we go to Section 3 now, the title 5 of the section is "The procedure for aspirating 6 blood clots from the brain is not 'significantly 7 different' from aspirating clots from the lungs or 8 legs." 9 Do you see that? 10 <b>A. Uh-huh. Yes.</b> 11 Q. Sitting here today, do you still believe 12 it to be true? 13 <b>A. Yes.</b> 14 Q. Actually, I should ask that in general. 15 Do you have any changes or corrections 16 that you believe need to be made to your 17 declaration? 18 <b>A. No.</b> 19 Q. So you, in these paragraphs, describe a 20 little bit of the procedure, the general procedure 21 of, you know, accessing the patient's blood vessels 22 and reaching the clot. And I wanted to ask a</p>

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1 question on paragraph 22.  
2 And you say "Once the aspiration catheter  
3 is near the clot, the physician will initiate  
4 aspiration; i.e., suction. In some simpler systems  
5 aspiration occurs by withdrawing the plunger on the  
6 syringe attached to the container to collect the  
7 aspirated material."  
8 Do you see that?  
9 **A. Yes.**  
10 Q. Are you aware of, you know, the  
11 differences in the containers or the plunger or the  
12 syringes, you know, between different devices? Are  
13 you aware of the mechanical differences in those  
14 devices?  
15 MR. STOWELL: Objection. Compound.  
16 THE WITNESS: The mechanical differences  
17 in those devices. I mean, some companies use a  
18 pump and some companies use a syringe. Do I  
19 know the mechanical properties of each one?  
20 No. But do I know the basic tenants of how to  
21 use a syringe and how to use a pump? Yes.  
22 You know, and I know the advantages and I

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1 understand the advantages and disadvantages of  
2 each system. So I'm not sure what exactly  
3 you're asking me in that context.  
4 BY MR. MILLER:  
5 Q. Do you know if you need a different  
6 syringe or pump for cardiovascular clots versus PE  
7 and DVT?  
8 **A. The -- I mean, there's not -- I mean, the**  
9 **only thing a syringe does is apply a certain amount**  
10 **of force. So I mean -- sorry, a certain volume of**  
11 **force. In other words, how much -- you know, if you**  
12 **don't have the blood clot or if you pull it through,**  
13 **how much blood you will get into it.**  
14 **So there's not anything special about a**  
15 **syringe that makes one for this or one for that as**  
16 **far as application-wise.**  
17 Q. And we might have talked about this a  
18 little bit earlier, but I wanted to ask it maybe in  
19 a different context.  
20 So when actually creating the aspiration  
21 or, you know, withdrawing the plunger on a syringe  
22 for example, when you've reached the blood clot, is

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1 it correct that you just, you know, pull the plunger  
2 all the way back, or is it kind of like a slow --  
3 I'm trying to understand how it actually happens.  
4 Is it a slow pull? Is it full pull?  
5 **A. Yeah, almost everybody uses a locking**  
6 **syringe. So you use a syringe where you -- you**  
7 **typically will -- what people typically will do is**  
8 **use a syringe hooked to a stop cock hooked to a**  
9 **catheter. And you take your syringe and pull it all**  
10 **the way back and you lock it. Otherwise, you're**  
11 **standing there trying to hold your syringe with it**  
12 **fully -- fully back and you're trying to do other**  
13 **things.**  
14 **So you typically pull it back, lock it,**  
15 **set it there. And your catheter is either at the**  
16 **clot or near the clot. And then when you're ready**  
17 **to apply aspiration to the clot, then you turn the**  
18 **aspiration stop cock on or open it, whatever term**  
19 **you want to use it, and that allows the aspiration**  
20 **clot force to be applied to the catheter.**  
21 **Again, the catheter is just simply a**  
22 **tool, a simple hose. That's all it is.**

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1 Q. So we talked a little bit earlier about  
2 kind of what makes someone an expert or, you know,  
3 what qualifications they would need.  
4 But I didn't ask, just generally, what's  
5 your view of -- you know, who would you consider a  
6 qualified expert in using aspiration catheters to  
7 treat, say, PE and DVT?  
8 **A. I mean --**  
9 MR. STOWELL: Objection. Vague.  
10 Go ahead.  
11 THE WITNESS: Sorry.  
12 I think it's about having the right  
13 training. In other words, they're trained to  
14 do the procedures on -- you know, that we're  
15 talking about. And -- and that they -- they  
16 actually have the case volume and the  
17 experience in doing these cases. As far as the  
18 specific number to assign to that, you know, I  
19 don't know that I have that. But I mean,  
20 they -- they -- should definitely be something  
21 that they do -- they do this for a living and  
22 they've got a reasonable amount of experience

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1 under their belt, meaning many years of doing  
2 it and at a high frequency.  
3 BY MR. MILLER:  
4 Q. When -- between when you submitted your  
5 declaration and the district court litigation, and  
6 when you submitted your declaration in the IPRs, did  
7 you do any additional work on the declaration?  
8 **A. No.**  
9 Q. Did your attorneys talk to you about your  
10 declaration before they submitted it in the IPRs?  
11 MR. STOWELL: Objection, vague.  
12 THE WITNESS: I have no idea. You'd have  
13 to ask him (indicating). We don't regularly  
14 talk, I'll put it that way. And the only thing  
15 when we communicate, it's only through this.  
16 BY MR. MILLER:  
17 Q. Did you draft the entirety of your  
18 declaration?  
19 **A. I didn't draft any of it.**  
20 Q. Did your attorneys draft it?  
21 **A. I don't know if the court reporter**  
22 **drafted it, I don't know if they did it. L..**

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1 Q. Do you know who Mr. Thornton is?  
2 **A. No.**  
3 Q. It's fair to say that you didn't consult  
4 with a Mr. Thornton in preparing your opinions in  
5 this case?  
6 **A. I -- I'm -- I'm not sure who Mr. Thornton**  
7 **is.**  
8 Q. I'll go back to your declaration for just  
9 a minute.  
10 Oh, you've mentioned a couple times this  
11 Penumbra device. You previously worked for the  
12 company that -- are you okay?  
13 **A. Yeah, just a little achy. But...**  
14 Q. You previously worked or consulted with  
15 Penumbra; correct?  
16 **A. Uh-huh. I've worked with and consulted**  
17 **with every medical device company in my field, I**  
18 **think, at one point or another.**  
19 Q. So we -- we talked about the ADAPT  
20 technique earlier.  
21 Is it true that you helped develop that  
22 technique?

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1 **A. Yes.**  
2 Q. Was that -- when you worked on that  
3 effort, did you work with catheter engineers or was  
4 it just doctors?  
5 **A. Yes, I mean, it was -- it was more we**  
6 **came up with how -- we basically came up with how to**  
7 **do aspiration. And, you know, if you -- if you go**  
8 **back to -- if you go back to that time period, you**  
9 **know, late -- you know, early 2010s, you know, at**  
10 **that time Penumbra had a system, it was called the**  
11 **Penumbra system. But it was an aspiration catheter.**  
12 **But it had a little -- it had a little wire, they**  
13 **called it a separator at the end, and it basically**  
14 **approximated the size of the opening of the distal**  
15 **catheter.**  
16 **And their theory was that we would suck a**  
17 **clot into the end of the catheter and you would take**  
18 **the separator and break up the clot and you would**  
19 **ingest the clot in that way.**  
20 **And what it basically effectively did is**  
21 **it took a big clot and made a clot -- when a blood**  
22 **vessel is in the head, the middle cerebral artery,**

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1 say, or any of the blood vessels in the head, when  
2 it branches, that first side of the blood vessel is  
3 called an M1. And then when it branches, the next  
4 branch level is called an M2. And then when it  
5 branches again and it's getting smaller, it's called  
6 an M3.  
7 So effectively what we did is we took an  
8 M1 blood clot and made it an M2 blood clot, and then  
9 an M2 blood clot an M3 blood clot. So we'd kind of  
10 have to size our way down and go smaller and  
11 smaller. So we basically fragmented these clots in  
12 smaller and smaller pieces. And that's how their  
13 system worked initially.  
14 And then a year or two later, we started  
15 getting these devices called stent retrievers. They  
16 were in Europe first, and they had been using them  
17 years and years and years. We didn't have them, but  
18 they worked a lot better than what we were doing.  
19 So, and then they eventually found that  
20 if they combined an aspiration catheter with a stent  
21 retriever, even better. So we got those in, like,  
22 2012 is my guess, my recollection. And we did a

<p style="text-align: center;">81</p> <p>1 handful of cases, probably 30 or so cases, with that 2 technique combined. And then we happened up on 3 aspiration alone, and it was like, wow, this kind of 4 actually works, like. 5 So I did a handful of cases and then I 6 called all my friends and said, hey, you got to try 7 this. So they, you know, eventually said, okay, 8 we'll give it a shot. And they're like, oh, wow, 9 hey, okay, it kind of works much of the time. But 10 it's just so fast and easy as a start, and then if 11 it doesn't work, then we can add the stent retriever 12 to it. 13 So that's kind of how we progressed into 14 aspiration at the time. And I was the one who 15 started it, I was the one who organized and got my 16 friends to do it and then wrote the initial papers 17 on it and eventually did a randomized trial on it. 18 Q. And when you were developing this 19 technique, did you try different aspiration 20 catheters, or it just doesn't matter what kind you 21 used? 22 A. Nobody else had has -- well, at that</p>	<p style="text-align: center;">83</p> <p>1 something -- it was when they -- it was when they 2 were Silk Road. They still had neuro in their area. 3 I'm sorry, they still had Silk -- they still -- the 4 informed -- they hadn't spun out Route 92 yet, and 5 it was all part of Silk Road. 6 Q. Were you familiar with any of the devices 7 that they designed? 8 A. I didn't have significant insight into 9 their -- into their tools, other than I knew that, 10 you know, clearly they obviously wanted a direct 11 carotid access. 12 And my involvement with them was -- you 13 know, they had numerous people that were very pro, 14 yes, you should develop a stroke system, you should 15 come do this. And I was a -- I was a nay sayer 16 saying nobody is going to do a carotid access system 17 and try to use carotid -- we don't need that, you 18 know. And they had some people that I think were 19 not -- well, you know, but... 20 But anyhow, they were debating whether to 21 develop a stroke system with -- through carotid 22 access.</p>
<p style="text-align: center;">82</p> <p>1 time, there was no aspiration catheter. Nobody else 2 made one. And there were no catheters that were 3 soft enough to get to that level or that location in 4 the anatomy. 5 Q. I'm trying to open something which might 6 make it faster than trying to find paper. 7 Have you ever heard of the company Silk 8 Road Medical? 9 A. Yes, I consulted for them as well. 10 Q. Do you know Michi Garrison? 11 (Reporter clarifies.) 12 THE WITNESS: No. 13 BY MR. MILLER: 14 Q. How about Tony Chow? 15 A. Yes. 16 Q. How do you know Tony? 17 A. I had the joy of having dinner with him 18 once, and, again, I consulted for Silk Road for a 19 bit. So I've been in a meeting or two with him. 20 Q. Do you know what timeframe you consulted 21 with him? 22 A. I would guess probably 2016, 2017-ish,</p>	<p style="text-align: center;">84</p> <p>1 Q. And why wouldn't you do a carotid access? 2 A. Because I think people with reasonable 3 catheter skills don't need it. Some of the people 4 that were advising them were not very skilled 5 operators in my opinion. And, yes, some of those 6 guys probably do have access issues; in other words, 7 ability to access the vessels off of the aortic arch 8 to be able to do a stroke procedure. You know, I 9 don't have those issues maybe one time in a year, 10 maybe at the most. And I think most reasonable 11 operators are around that number. And that just to 12 me doesn't justify doing a carotid access as a main 13 technique. 14 Q. Do you know the company Angiodynamics? 15 A. Yes. 16 Q. How do you know them? 17 A. They make devices that we occasionally 18 use. 19 Q. Do you know a Leshawn McClog? 20 A. No. 21 Q. How about a Michael Glennon? 22 A. I -- I don't know anybody at the company.</p>

<p style="text-align: right;">85</p> <p>1 <b>I mean, I've never consulted with them. They make</b> 2 <b>catheters that we stock and...</b> 3 Q. Have you ever used one of their devices? 4 <b>A. I mean, I've used some of their</b> 5 <b>catheters, that are diagnostic catheters, but...</b> 6 Q. What is the difference between a 7 diagnostic catheter and one you would use for 8 aspiration? 9 <b>A. Oh, yeah, so a diagnostic catheter is</b> 10 <b>like a 20-dollar catheter that you use to go up and</b> 11 <b>take pictures with. And they come in different</b> 12 <b>shapes, the tip. So you -- based on the tip shape,</b> 13 <b>we tend to use certain ones more than others.</b> 14 Q. Do you know a David Schaffer? 15 <b>A. No. I know a Michael Schaffer.</b> 16 Q. How familiar are you with the design 17 process of aspiration catheters? 18 MR. STOWELL: Objection. Vague. 19 THE WITNESS: I guess the way I would say 20 it is I think I'm pretty -- I think I have a 21 pretty good idea of it for a doctor, but I 22 certainly don't know the level of it as an</p>	<p style="text-align: right;">87</p> <p>1 Q. -- right? 2 And there's at least some level of 3 engineering design that goes into developing 4 aspiration catheters; correct? 5 <b>A. Yes.</b> 6 Q. And I assume there -- there are also 7 engineering -- or some level of engineering design 8 that goes into developing the pumps or the 9 connections to the pumps and the catheters; correct? 10 <b>A. Yeah, I mean, I -- yes.</b> 11 <b>But I think that's a much more</b> 12 <b>straightforward -- the pump -- the pump itself I</b> 13 <b>think is a very straightforward entity and process</b> 14 <b>compared to the catheters.</b> 15 Q. What are all -- I know that we've talked 16 about them in maybe different areas of this 17 deposition but -- are you okay? 18 <b>A. Yeah, I'm just trying to -- foot goes</b> 19 <b>numb here and there and then you got to figure out</b> 20 <b>if there's not enough blood or much blood. I'm</b> 21 <b>good.</b> 22 Q. Don't get a clot.</p>
<p style="text-align: right;">86</p> <p>1 engineer. 2 BY MR. MILLER: 3 Q. I mean, you've said a couple times that 4 the -- in your view, these are dumb tubes? 5 <b>A. Uh-huh.</b> 6 Q. Is that a "yes"? 7 <b>A. Yes.</b> 8 Q. And I assume -- 9 <b>A. Well, let me back up. I want to clarify</b> 10 <b>that in that they're dumb tubes insofar as how they</b> 11 <b>perform aspiration; in other words, it's a mechanism</b> 12 <b>to transmit an aspiration force from the hub to the</b> 13 <b>tip. That's all it is. They're very sophisticated</b> 14 <b>tools, some more than others, obviously, in -- in</b> 15 <b>construction and design to be able to navigate and</b> 16 <b>perform in the selected anatomies.</b> 17 Q. You again predicted where I was going 18 with my questions. 19 <b>A. Okay.</b> 20 Q. Imperative obviously employs design 21 engineers -- 22 <b>A. Yes.</b></p>	<p style="text-align: right;">88</p> <p>1 <b>A. No, that's a different set of symptoms.</b> 2 Q. What are, in your view, the different 3 design choices that go into engineering a catheter. 4 Like, at a high level, what are the engineering 5 design choices or categories? 6 <b>A. Yes, to me, when they're designing a</b> 7 <b>catheter, they've got to -- they obviously have</b> 8 <b>to -- the engineers will figure out the right</b> 9 <b>materials; in other words, what types of plastics or</b> 10 <b>what liners do they need, what -- you know, what</b> 11 <b>reinforcement methods are they going to use for the</b> 12 <b>catheter design. You know, there's things like --</b> 13 <b>you know, in today's world you can have laser cut</b> 14 <b>hypo tubes, you can have a brain design, you know,</b> 15 <b>you can have all different types of catheter</b> 16 <b>construction materials. And that's something the</b> 17 <b>engineers are going to figure out, what they feel is</b> 18 <b>the best way to do that.</b> 19 <b>Where we typically involve on the</b> 20 <b>physician side is helping them understand, okay, we</b> 21 <b>want the catheter to get to this position, and</b> 22 <b>here's the anatomy we have to navigate through and</b></p>

<p style="text-align: center;">89</p> <p>1 <b>where are the -- you know, what lengths do we</b> 2 <b>transition from being super soft to soft but a</b> 3 <b>little bit of support to very supportive, and where</b> 4 <b>do those transitions occur and how do they make</b> 5 <b>those transitions happen.</b> 6 Q. So to -- to properly design one of these 7 catheters, these engineers need to talk to 8 physicians -- 9 <b>A. Yes.</b> 10 Q. -- or consult with them; right? 11 <b>A. Yeah. And then once you actually make</b> 12 <b>the catheter, you have to take it out and use it on</b> 13 <b>some people. And then you typically have to iterate</b> 14 <b>it after that as well, to, you know, tweak something</b> 15 <b>here or there. Maybe we need a little more support</b> 16 <b>here and a little less support here and a little</b> 17 <b>more flexibility here. And then you have a product</b> 18 <b>that will be a commercial success.</b> 19 Q. So generally, for instance, at 20 Imperative, your design engineers would consult with 21 physicians or you before making some substantial 22 modifications to the device?</p>	<p style="text-align: center;">91</p> <p>1 wouldn't make a substantive change to it without 2 consulting a doctor; right? 3 MR. STOWELL: Objection. Vague. 4 THE WITNESS: I'm sure a lot of them 5 would. But I wouldn't think it would -- I 6 wouldn't think it would end well. Or I 7 wouldn't think it would be a success -- I mean, 8 in my opinion, the successful endeavors that 9 are out there start with an engineer developing 10 something. You put it to use. You find where 11 does it excel, where does it not excel, and 12 what changes can we make to improve it. And 13 then they go back and make those changes, come 14 back and try it, and, hey, that's great or now 15 it's you need to do this even more. 16 And that's how you -- and I say that 17 because we did that with Imperative. Our zoom 18 catheters are -- you know, some of them are the 19 most frequently used out there commercially, 20 but it's because we had to iterate. You know, 21 we had engineers that worked with doctors early 22 on, and then we refined it as it was used.</p>
<p style="text-align: center;">90</p> <p>1 <b>A. Well, I mean, that's part of it. So if</b> 2 <b>you look at Imperative Care, the big difference at</b> 3 <b>Imperative Care is we have four physicians that we</b> 4 <b>all -- we're the early people with aspiration. And</b> 5 <b>we founded this ten years ago before aspiration was</b> 6 <b>really a thing. And now that it's a thing,</b> 7 <b>Imperative is well positioned because we've got</b> 8 <b>so -- we've always been a believer in it, and we</b> 9 <b>didn't, you know, start it three years ago, we</b> 10 <b>started it ten years ago. And we've iterated and</b> 11 <b>developed our way that way, and we did it by</b> 12 <b>specifically doctors working with engineers to</b> 13 <b>develop these products specifically for stroke</b> 14 <b>thrombectomy.</b> 15 <b>And once we did that, we said, oh, hey,</b> 16 <b>we can apply this to peripheral and, you know, and</b> 17 <b>PE and DVT and all that other stuff just like</b> 18 <b>Penumbra did. We took a page out of their playbook</b> 19 <b>to do it.</b> 20 Q. Yeah, and I guess my question was more 21 specific or I guess more general. 22 A design engineer making a catheter</p>	<p style="text-align: center;">92</p> <p>1 And then you look at companies like 2 Medtronic, Stryker and they had gone through 3 five or six iterations of aspiration catheters, 4 but they don't -- they don't iterate and do it 5 in the way that I just mentioned. 6 MR. MILLER: And it's Stryker, 7 S-T-R-Y-K-E-R. 8 THE WITNESS: Yes. 9 BY MR. MILLER: 10 Q. Who are Imperative's primary competitors? 11 <b>A. Anybody that makes aspiration catheters.</b> 12 <b>Anybody that treats ischemic stroke, I should say.</b> 13 <b>Anybody that treats PE, DVT.</b> 14 <b>Want specific names? Medtronic, Stryker,</b> 15 <b>MicroVention Terumo --</b> 16 (Reporter clarifies.) 17 THE WITNESS: T-E-R-U-M-O. 18 Johnson &amp; Johnson and its various names 19 of -- Cerenovus or whatever they call 20 themselves these days. Penumbra. You know, 21 which -- you know, all the frequent 22 acquisitions, they're all combining now, but,</p>

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1     yeah.  
2 BY MR. MILLER:  
3     Q.   Is it fair to say that Imperative stands  
4 to gain if the patents here are found unpatentable  
5 and not used against Imperative?  
6     **A.   I mean, I guess it's all in your**  
7 **perspective. I mean, we don't have a very big**  
8 **peripheral vascular business at the moment, so I**  
9 **don't think we gain anything. But we certainly**  
10 **wouldn't -- won't build it if we don't have a solid**  
11 **foundation to build on. I'd say we probably have a**  
12 **lot to lose, but, you know, or -- or opportunity,**  
13 **however you want to say it.**  
14     MR. MILLER: Can we take a ten-minute  
15 break?  
16     MR. STOWELL: Sure.  
17     MR. MILLER: Thanks.  
18     THE VIDEOGRAPHER: The time now is 10:30  
19 a.m. We are now off the record.  
20     (A brief recess was taken.)  
21     THE VIDEOGRAPHER: Back on the video  
22 record. The time now is 10:43 a.m.

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1     Counsel, you may proceed.  
2 BY MR. MILLER:  
3     Q.   So I know we've looked at this table of  
4 exhibits --  
5     **A.   Yep.**  
6     Q.   -- so many times. And I'm sorry to make  
7 you look at it one more time.  
8     **A.   No problem.**  
9     Q.   So I've asked you about a few specific  
10 things on here, including the patents and a few of  
11 these other exhibit numbers. And I just wanted to  
12 walk through a few of them just to confirm one way  
13 or another that you haven't read them.  
14     So we talked about Exhibit 1005 and  
15 Exhibit 1006. Have you read any of between Exhibit  
16 1007 and Exhibit 1020?  
17     MR. STOWELL: Just for the record, the  
18 documents aren't in front of Dr. Turk, so he's  
19 operating based on recollection.  
20     THE WITNESS: Yeah, I mean, not that I'm  
21 aware of.  
22

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1 BY MR. MILLER:  
2     Q.   Dr. Turk, do you consider yourself an  
3 expert in treating PE and DVT?  
4     **A.   No.**  
5     Q.   Do you consider yourself an expert in  
6 mechanical thrombectomy?  
7     **A.   Yes.**  
8     Q.   Do you consider yourself an expert in  
9 mechanical thrombectomy for any type of clot or only  
10 with respect to neurovascular clots?  
11     **A.   I think I -- I don't know the way to**  
12 **answer that. I think I have a lot of expertise when**  
13 **it comes to the understanding of fundamentals and**  
14 **the principals of aspiration thrombectomy. I think**  
15 **when it comes to stroke thrombectomy, I'm -- I think**  
16 **I have a tremendous amount of expertise in that both**  
17 **conceptually and, you know, a very busy practice and**  
18 **a lot of experience in case volume.**  
19     **I'll leave it at that.**  
20     Q.   But you haven't -- strike it.  
21     During the breaks today, have you  
22 discussed the substance of your testimony with

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1 anyone?  
2     **A.   No. We've talked about insurance.**  
3 **Homeowner's insurance, that is.**  
4     Q.   With respect to other types of -- so you  
5 stated that you have tremendous amounts of  
6 experience with stroke thrombectomy.  
7     You don't have the same level of  
8 experience with PE and DVT thrombectomy; correct?  
9     **A.   Correct.**  
10     **I've done 50 to 100 -- personally 50 to**  
11 **100 stroke thrombectomy cases a year for 15, 20**  
12 **years, so...**  
13     MR. MILLER: I believe we've already made  
14 this objection on the record before the board,  
15 but we'll make it again here.  
16     Respondent objects to Dr. Turk's  
17 testimony including his declarations for lack  
18 of relevance to the patents and that his  
19 testimony is unreliable for not having  
20 considered the prior art or the patents  
21 themselves. Just putting that on the record.  
22     MR. STOWELL: We disagree.


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1 MR. MILLER: I have no further questions  
2 pending redirect.  
3 MR. STOWELL: I do not have any questions  
4 for Dr. Turk.  
5 There was one detail that came up during  
6 the deposition today that may be subject to  
7 confidentiality, and that is Dr. Turk's  
8 compensation as chief medical officer. I'm  
9 working on getting confirmation from the client  
10 as to whether that is confidential information.  
11 James, if we could agree to keep the  
12 rough confidential and only disclose it to  
13 outside attorneys' eyes only for now, I will  
14 email you within the next day or so to let you  
15 know whether I need to mark that small section  
16 of the transcript confidential.  
17 MR. MILLER: Totally fine.  
18 MR. STOWELL: Great. With that, I have  
19 no further comments.  
20 THE WITNESS: Awesome.  
21 THE VIDEOGRAPHER: The time now is 10:50  
22 and this marks the end of the deposition of

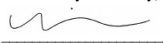
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1 Dr. Aquilla Turk, III. Thank you, everyone.  
2 (Deposition concluded at 10:50 a.m.)  
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2 CERTIFICATE OF OATH  
3 STATE OF FLORIDA  
4 COUNTY OF PALM BEACH  
5  
6  
7 I, the undersigned authority, certify that  
8 AQUILLA S. TURK, III personally appeared before me  
9 and was duly sworn.  
10  
11 Dated this 26th day of February, 2026.  
12  
13  
14  
15  
  
16 Pamela J. Pelino, RPR, FPR, CLR  
17 Notary Public - State of Florida  
18 Commission No.: HH 275669  
19 Commission Expires: June 13, 2026  
20  
21  
22

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1 CERTIFICATE  
2 STATE OF FLORIDA  
3 COUNTY OF PALM BEACH  
4  
5 I, Pamela J. Pelino, Registered  
6 Professional Court Reporter and Notary Public in and  
7 for the State of Florida at Large, do hereby certify  
8 that the aforementioned witness was by me first duly  
9 sworn to testify the whole truth; that I was  
10 authorized to and did report said deposition in  
11 stenotype; and that the foregoing pages are a true  
12 and correct transcription of my shorthand notes of  
13 said deposition.  
14 I further certify that said deposition was  
15 taken at the time and place hereinabove set forth  
16 and that the taking of said deposition was commenced  
17 and completed as hereinabove set out.  
18  
19 I further certify that I am not attorney  
20 or counsel of any of the parties, nor am I a  
21 relative or employee of any attorney or counsel of  
22 party connected with the action, nor am I  
financially interested in the action.  
The foregoing certification of this  
transcript does not apply to any reproduction of the  
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Dated this 26th day of February, 2026.  
  
Pamela J. Pelino, RPR, FPR, CLR

<b>A</b>			
<b>ability</b>	<b>actual</b>	<b>aforementioned</b>	<b>allowed</b>
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<b>able</b>	<b>actually</b>	<b>after</b>	<b>allows</b>
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<b>accessing</b>	<b>add</b>	<b>agree</b>	<b>also</b>
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	<b>affect</b>		<b>aneurysm</b>
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	<b>affects</b>		
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