

DID YOU KNOW?

**OVER 2.5 MILLION PATIENTS HAVE  
HAD MINIMALLY INVASIVE *DA VINCI*<sup>®</sup>  
SURGERY WORLDWIDE SINCE 2000**



Licensed by Intuitive Surgical April 2015

YOUR HOSPITAL  
LOGO HERE

At XXXXXXXXXXXXXXXXXXXX Hospital, we are committed to providing superior patient care and being a leader in healthcare excellence and innovation in the communities we serve. In 0000, we started our Robotic-Assisted Surgery Program and added *da Vinci*® Surgery to expand our range of services to offer another minimally invasive surgical option to patients.



**CUSTOMIZATION AREA: PLEASE INSERT A QUOTE FROM ONE OF YOUR DA VINCI SURGERY PATIENTS HERE.**

- patient's first name, specific *da Vinci* procedure



### WHAT DOES OUR ROBOTIC-ASSISTED SURGERY PROGRAM OFFER?

The Robotic-Assisted Surgery Program at xxxx hospital has a multidisciplinary surgical team. ## surgeons are specially trained and credentialed to perform robotic-assisted *da Vinci* Surgery. A dedicated, highly experienced team of anesthesiologists, nurses, assistants and surgical techs are also trained to support each surgeon's needs during robotic-assisted surgery.

Our *da Vinci* Robotic-Assisted Surgery Service Lines include:

- |                    |                     |                  |
|--------------------|---------------------|------------------|
| Bariatric Surgery  | General Surgery     | Thoracic Surgery |
| Cardiac Surgery    | Gynecologic Surgery | Urology Surgery  |
| Colorectal Surgery | Head & Neck Surgery |                  |

**PHOTO OF YOUR ROBOTIC-ASSISTED SURGERY CENTER OR TEAM**

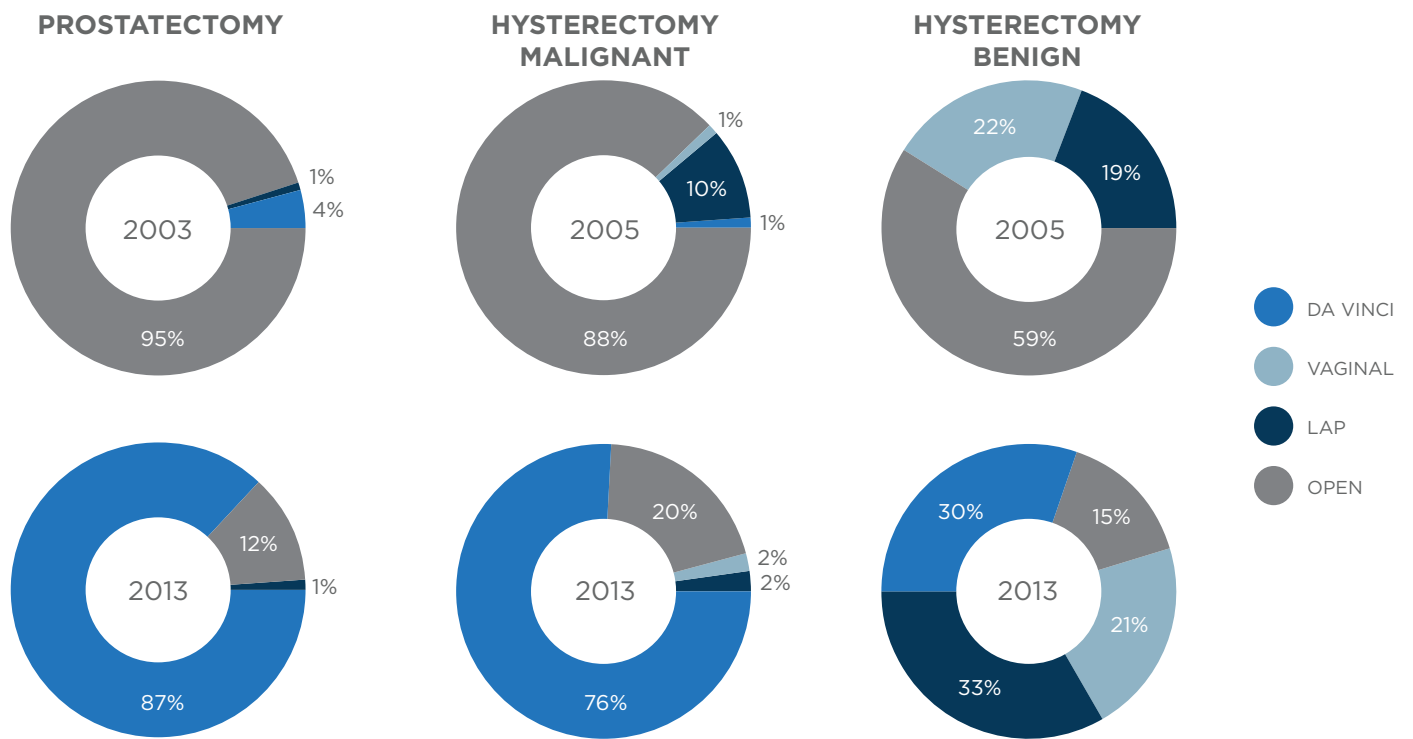
### WHAT IS DA VINCI SURGERY?

*da Vinci* Surgery is a type of minimally invasive surgery where specially trained surgeons use the *da Vinci* robotic-assisted surgical system to perform a wide range of delicate and complex operations. The *da Vinci* System features a magnified 3D high-definition vision system and tiny wristed instruments that bend and rotate far greater than the human wrist. As a result, *the da Vinci System* enables surgeons to operate with enhanced vision, precision, dexterity and control.

## OUR GOAL: EXTEND MINIMALLY INVASIVE SURGERY (MIS) TO MORE PATIENTS

At **xxx hospital**, we believe that MIS should be the standard of care in surgery. For decades, patients receiving open surgery continued to be the majority for many procedures even when MIS options were available. Finally, the adoption of minimally invasive *da Vinci* Surgery has changed this for several procedures and has begun changing for others. That’s a major reason why **xxx hospital** continues to expand our robotic-assisted surgery services, so that fewer and fewer patients will receive open surgery if they qualify for MIS procedures.

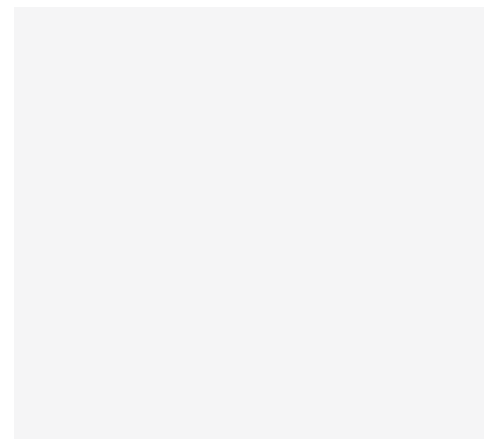
### ESTIMATED ADOPTION OF MINIMALLY INVASIVE SURGERY IN THE U.S. (as % of procedures)<sup>I-III</sup>



Total may not add up to 100% due to rounding.

Sources: I. Inpatient data: Nationwide Inpatient Sample (NIS), Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality. II. Outpatient data: Truven Health Analytics. III. *da Vinci* data: ISI Internal Estimates

**ADD A PATIENT STORY WITH PHOTO**





## WHY OUR SURGEONS OFFER *DA VINCI*<sup>®</sup> SURGERY

As physicians, our ultimate responsibilities are to our patients. We believe in offering our patients all the treatment and surgical options supported by evidence-based medicine. That includes minimally invasive *da Vinci* surgery. More than 9,500 peer-reviewed studies and reports examining the use of the *da Vinci* Surgical System in various procedures have been published. The publications include the following types: randomized studies, systematic reviews, prospective and retrospective comparison studies, single arm studies, literature reviews, case studies, cadaver studies, animal studies and editorials.

### KEY POTENTIAL PATIENT BENEFITS OF *DA VINCI* SURGERY VS. OPEN SURGERY\*:

- A shorter hospital stay<sup>1-5</sup>
- Less blood loss<sup>2-4,6</sup>
- Fewer complications<sup>2- 4,7-8</sup>
- Less need for narcotic pain medicine<sup>1,7,9-10</sup>
- A faster recovery <sup>1-2,11-12</sup>
- Smaller incisions associated with minimal scarring<sup>3,6-7</sup>

\* Potential benefits are specific to the procedure referenced in the footnoted publications.

## IMPORTANT SAFETY INFORMATION

Serious complications may occur in any surgery, including *da Vinci*<sup>®</sup> Surgery, up to and including death. Examples of serious or life-threatening complications, which may require prolonged and/or unexpected hospitalization and/or reoperation, include but are not limited to, one or more of the following: injury to tissues/organs, bleeding, infection and internal scarring that can cause long-lasting dysfunction/pain. Risks of surgery also include the potential for equipment failure and/or human error. Individual surgical results may vary.

Risks specific to minimally invasive surgery, including *da Vinci* Surgery, include but are not limited to, one or more of the following: temporary pain/nerve injury associated with positioning; temporary pain/discomfort from the use of air or gas in the procedure; a longer operation and time under anesthesia and conversion to another surgical technique. If your doctor needs to convert the surgery to another surgical technique, this could result in a longer operative time, additional time under anesthesia, additional or larger incisions and/or increased complications.

Patients who are not candidates for non-robotic minimally invasive surgery are also not candidates for *da Vinci*<sup>®</sup> Surgery. Patients should talk to their doctor to decide if *da Vinci* Surgery is right for them. Patients and doctors should review all available information on non-surgical and surgical options in order to make an informed decision. For Important Safety Information, including surgical risks, indications, and considerations and contraindications for use, please also refer to [www.davincisurgery.com/safety](http://www.davincisurgery.com/safety) and [www.intuitivesurgical.com](http://www.intuitivesurgical.com).

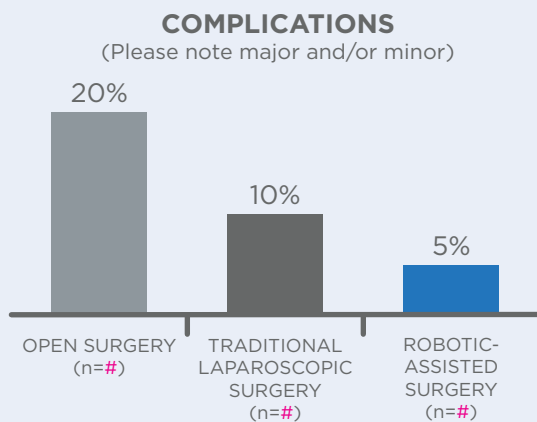
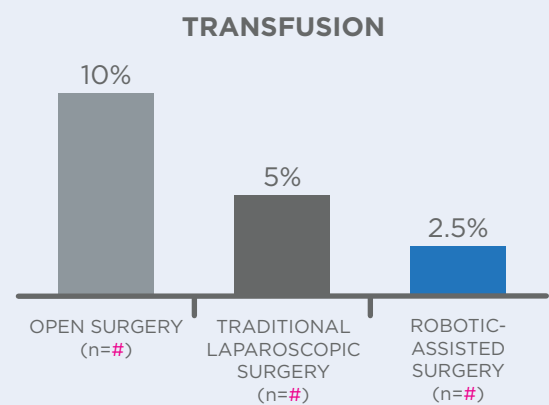
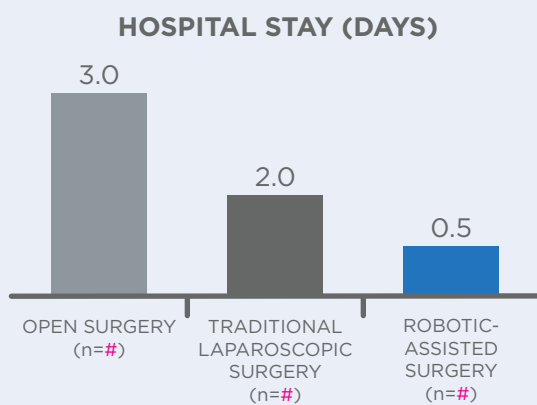
## ROBOTIC-ASSISTED SURGERY AT XXXXXX HOSPITAL

SINCE 0000	COLORECTAL & GENERAL SURGERY	GYNECOLOGY SURGERY	UROLOGY SURGERY	TOTAL
# OF PATIENTS WHO HAVE HAD DA VINCI SURGERY	XX	XX	XX	XX
AS % OF ALL SURGICAL PATIENTS	XX%	XX%	XX%	XX%
AGE: MEAN (RANGE)	XX	XX	XX	XX
BMI: MEAN (RANGE)	XX	XX	XX	XX

## ROBOTIC-ASSISTED SURGERY PROCEDURES AT XXXXXX HOSPITAL

- XXXXXXXXXXXX Surgery
- XXXXXXXXXXXX Surgery
- XXXXXXXXXXXX Surgery
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- XXXXXXXXXXXX Surgery
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- XXXXXXXXXXXX Surgery

## CLINICAL OUTCOMES COMPARISON: [PROCEDURE NAME]



*Data shown is for illustrative purposes only. Please replace with your own data.*



**CUSTOMIZATION AREA: PLEASE INSERT A QUOTE FROM A DA VINCI SURGEON ABOUT HOW DA VINCI SURGERY BENEFITS PATIENTS AND WHY.**

- surgeon's name, specialty



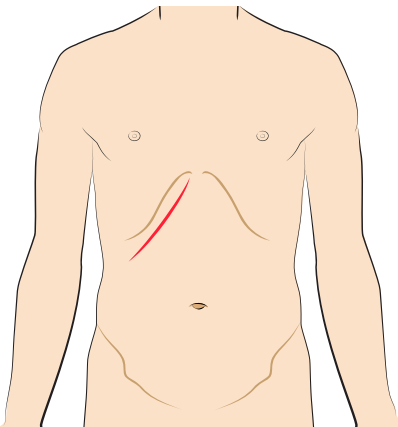
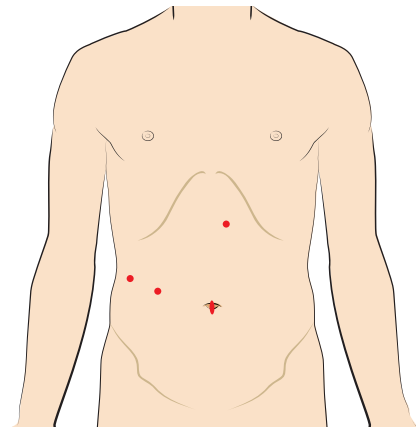
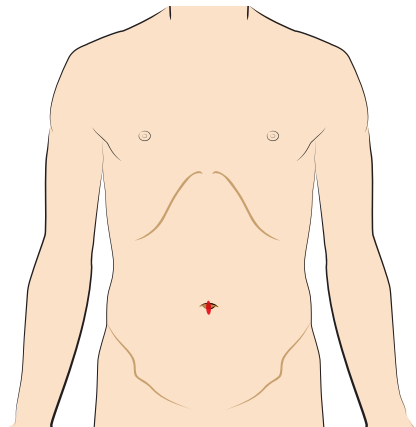
## HOW DOES THE DA VINCI® SURGICAL SYSTEM WORK?

Using the *da Vinci* Surgical System, surgeons perform delicate and complex operations through a few small incisions. The *da Vinci* System consists of several key components, including:

- an ergonomically designed console where the surgeon sits while operating
- a patient-side cart with interactive robotic arms
- a 3D HD vision system
- *EndoWrist*® instruments that bend and rotate far greater than the human wrist

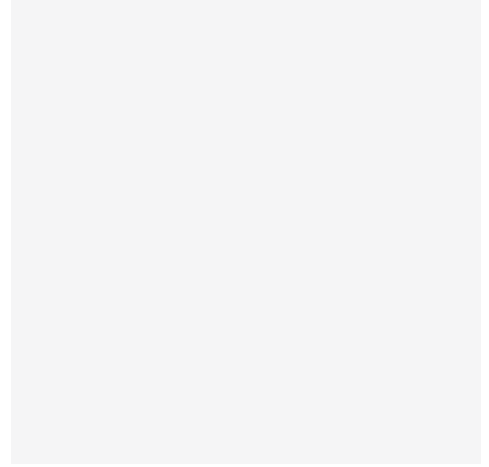
*da Vinci* software can scale down surgeon's movements and minimize the effects of a surgeon's hand tremors on instrument movements. As a result, the *da Vinci* System enables surgeons to operate with enhanced vision, precision, dexterity and control.

## SURGICAL INCISION COMPARISON

COLECTOMY	CHOLECYSTECTOMY	
		
<p><b>ONE LARGE INCISION</b> Open Colectomy</p>	<p><b>MULTIPLE SMALL INCISIONS</b> <i>da Vinci</i>® Colectomy; Multi-port or Traditional Laparoscopic Colectomy</p>	<p><b>ONE SMALL INCISION IN THE BELLY BUTTON</b> <i>da Vinci Single-Site</i>® Cholecystectomy or Traditional Laparoscopic Single Incision Cholecystectomy</p>
<p><small>*Traditional laparoscopic single incision Cholecystectomy is not a widely available surgical procedure.</small></p>		

*da Vinci* Surgery with *Single-Site*® Instruments is cleared for use in gallbladder removal, and for hysterectomy and ovary removal for benign conditions. Patients who are not candidates for non-robotic minimally invasive surgery are also not candidates for *da Vinci* Surgery, including *da Vinci* Surgery with *Single-Site*® Instruments. There may be an increased risk of incision-site hernia with single-incision surgery, including *Single-Site* surgery with *da Vinci*. Please also refer to [www.daVinciSurgery.com/Safety](http://www.daVinciSurgery.com/Safety) for Important Safety Information.

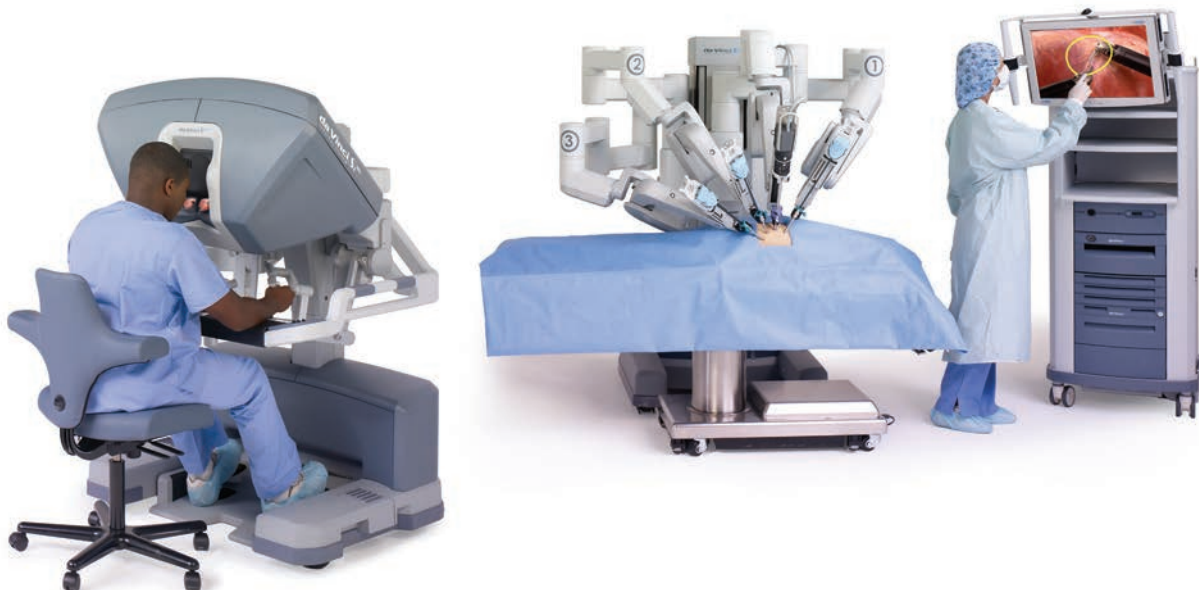
## ADD A PATIENT STORY WITH PHOTO



### IS DA VINCI SURGERY COVERED BY INSURANCE?

Surgery with the *da Vinci* Surgical System is a type of minimally invasive surgery. You can tell your patients that most insurance plans include *da Vinci* Surgery in their minimally invasive coverage. Major insurance plans, including United, Aetna and Blue Cross Blue Shield, cover *da Vinci* Surgery. Your patients should check with their insurance provider to confirm coverage.

Intuitive Surgical and its contractor organizations provide reimbursement information for illustrative purposes only. We cannot guarantee the comprehensiveness, accuracy, or timeliness of this information given the frequent change in public and private reimbursement. We urge healthcare providers to seek counsel from reimbursement experts for guidance in any issues or concerns relating to coverage, coding, and payment. Determination of coverage under a member's benefit plan does not guarantee provider reimbursement. The determination that a service, procedure, item, etc. is covered under a member's benefit plan and use of correct coding does not guarantee that providers will be reimbursed.



## MEET OUR *ROBOTIC-ASSISTED* SURGERY SURGEONS

 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>
 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>	 <i>Fist Last, MD</i> <i>Type of Surgery</i>

**PLEASE CUSTOMIZE THE NAME AND SURGERY TYPE**



**CUSTOMIZATION AREA: PLEASE INSERT A QUOTE FROM A *DA VINCI* SURGEON ABOUT WHY HE/SHE RECOMMENDS *DA VINCI* SURGERY.**

- surgeon's name, specialty





**GYNECOLOGY SURGERY**

**First Last, MD**

**GYN Oncology surgeon**

*I offer da Vinci Surgery:  
Hysterectomy (with Single-Site®  
too)  
Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**First Last, MD**

**GYN Oncology surgeon**

*I offer da Vinci Surgery:  
Hysterectomy (with Single-Site®  
too)  
Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**CARDIOTHORACIC SURGERY**

**First Last, MD**

**GYN Oncology surgeon**

*I offer da Vinci Surgery:  
Hysterectomy (with Single-Site®  
too)  
Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**First Last, MD**

**GYN Oncology surgeon**

*I offer da Vinci Surgery:  
Hysterectomy (with Single-Site®  
too)  
Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**First Last, MD**

**GYN Oncology surgeon**

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Myomectomy  
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Endometriosis resection*

**First Last, MD**

**GYN Oncology surgeon**

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Hysterectomy (with Single-Site®  
too)  
Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**COLORRECTAL & GENERAL SURGERY**

**First Last, MD**

**GYN Oncology surgeon**

*I offer da Vinci Surgery:  
Hysterectomy (with Single-Site®  
too)  
Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**First Last, MD**

**GYN Oncology surgeon**

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**GYN Oncology surgeon**

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Hysterectomy (with Single-Site®  
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Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**HEAD & NECK SURGERY**

**First Last, MD**

**GYN Oncology surgeon**

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Hysterectomy (with Single-Site®  
too)  
Myomectomy  
Sacrocolpopexy  
Endometriosis resection*

**First Last, MD**

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Endometriosis resection*

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**GYN Oncology surgeon**

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Hysterectomy (with Single-Site®  
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Sacrocolpopexy  
Endometriosis resection*

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NOTE: The referenced studies evaluated an *Si* or earlier model of the *da Vinci* Surgical System. There is no clinical data currently available for the *da Vinci Xi* Surgical System. The *da Vinci Xi* Surgical System is not cleared for use in transoral otolaryngology surgical procedures and is not specifically cleared for use in prostatectomy. It is cleared for use in urologic surgical procedures.

In order to provide benefit and risk information, Intuitive Surgical reviews the highest available level of evidence on representative *da Vinci* procedures. Intuitive Surgical strives to provide a complete, fair and balanced view of the clinical literature. However, our materials should not be seen as a substitute for a comprehensive literature review for inclusion of all potential outcomes. We encourage patients and physicians to review the original publications and all available literature in order to make an informed decision. Clinical studies are available at [pubmed.gov](http://pubmed.gov).

The implementation of a *da Vinci*<sup>®</sup> Surgery program is practice- and hospital-specific. Results may vary. Past customer experience does not imply any guarantee of results in practice or program success. When considering cost-effectiveness of an advanced technology like the *da Vinci* System, we recommend that hospitals perform a full cost-benefit analysis, considering not just the operating room costs but the costs associated with hospital stays, procedure-related complications and hospital re-admissions.

Unless otherwise noted, all people depicted are models. Product names are trademarks or registered trademarks of their respective holders. PN 1016560 rev A 5/15

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HOSPITAL NAME | HOSPITAL WEBSITE URL | To refer a patient, please call 000-000-0000.

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**TO REFER PATIENTS TO A SURGEON AT **XXXX**  
**HOSPITAL**, PLEASE CALL **000-000-0000**.**

For more information or questions  
about our surgeons and hospital  
services, contact [xxxxxxxx@xxxx.com](mailto:xxxxxxxx@xxxx.com)

**000-000-0000**

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events, service updates, and patient  
information resources.

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## CLINICAL EVIDENCE HIGHLIGHTS: VENTRAL HERNIA REPAIR

The breadth and depth of literature regarding *da Vinci*® Surgery is extensive. More than 9,500 peer-reviewed studies and reports examining the use of the *da Vinci* Surgical System in various procedures have been published. This section features sample published clinical literature summaries. These summaries should not be seen as a substitute for a comprehensive literature review.

### **LAPAROSCOPIC VENTRAL HERNIA REPAIR WITH PRIMARY CLOSURE VERSUS NO PRIMARY CLOSURE OF THE DEFECT: POTENTIAL BENEFITS OF THE ROBOTIC TECHNOLOGY**

Gonzalez AM, Romero RJ, Seetharamaiah R, et al. *Int J Med Robot.* 2014 Sep 18.

#### **ABSTRACT**

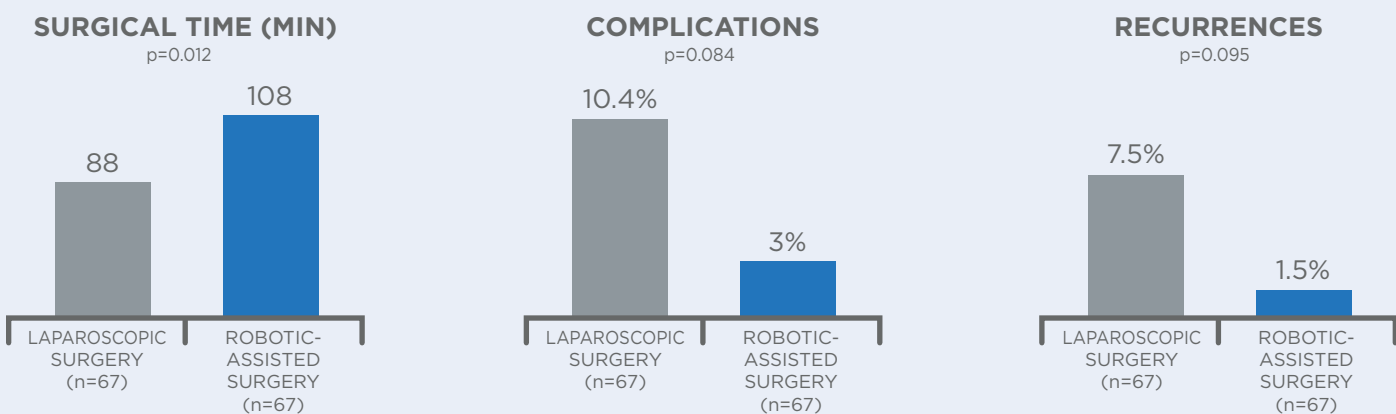
**Background:** Some authors recommend primary closure of the defect before placement of the mesh. The purpose of this study is to compare laparoscopic ventral hernia repair (LVHR) without primary closure of the defect (NPCD) versus LVHR with primary closure of the defect (PCD).

**Methods:** A retrospective review of 134 LVHR was performed. Each group included 67 cases. For the PCD group the robotic platform was used.

**Results:** Groups were similar in terms of demographics and comorbidities. For NPCD and PCD groups mean surgical time was  $87.9 \pm 53.1$  and  $107.6 \pm 33.9$  minutes ( $p = 0.012$ ); conversion to open surgery was seen in 3(4.5%) and 1(1.5%) ( $p = 0.310$ ); complications were 7(10.4%) and 2(3%) ( $p = 0.084$ ); and finally, recurrences were seen in 5(7.5%) and 1(1.5%) ( $p = 0.095$ ).

**Conclusions:** PCD has longer surgical time, however, a tendency in terms of complications and recurrences was found favoring the PCD group. The robotic assistance is a good alternative when primary closure of the defect is attempted.

### COMPARISON OF CLINICAL OUTCOMES



*Study limitations discussed by the authors:* This is a retrospective study of data from a single institution. "Further studies are needed to compare outcomes of closure of the defect with both, laparoscopic and robotic approaches." Conflict of interest: The authors have stated explicitly that there are no conflicts of interest in connection with this article.



## CLINICAL EVIDENCE HIGHLIGHTS: RECTAL CANCER SURGERY

The breadth and depth of literature regarding *da Vinci*® Surgery is extensive. More than 9,500 peer-reviewed studies and reports examining the use of the *da Vinci* Surgical System in various procedures have been published. This section features sample published clinical literature summaries. These summaries should not be seen as a substitute for a comprehensive literature review.

### **THE IMPACT OF ROBOTIC SURGERY FOR MID AND LOW RECTAL CANCER A CASE-MATCHED ANALYSIS OF 3-ARM COMPARISON—OPEN, LAPAROSCOPIC, AND ROBOTIC SURGERY**

Kang J, Yoon KJ, Min BS, et al. *Annals of Surgery*. 257(1):95-101, January 2013.

#### **ABSTRACT**

**Objective:** The objective of this study was to clarify the impact of robotic surgery (RS) in the management of mid- and low rectal cancer in comparison with open surgery (OS) and laparoscopic surgery (LS).

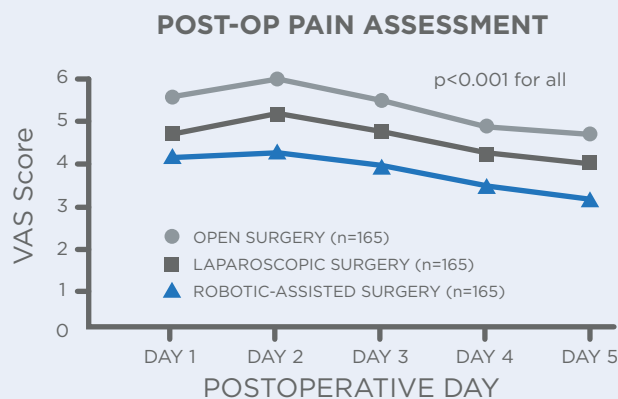
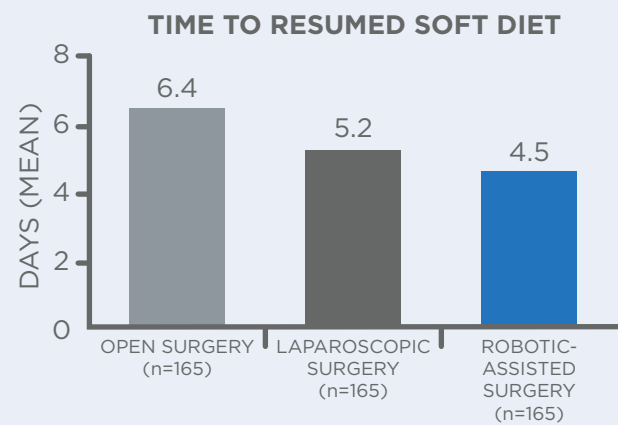
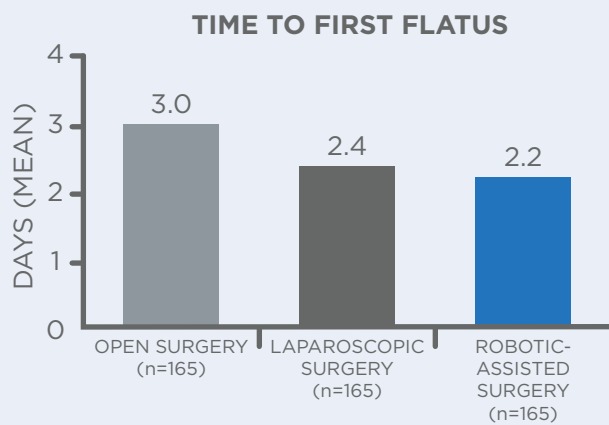
**Background:** The benefits of RS in the treatment of rectal cancer have not yet been clearly described

**Methods:** Using propensity scores for adjustment of sex, age, body mass index, tumor stage, and tumor height, a well-balanced cohort with 165 patients in each group, was created by matching each patient who underwent RS as the study group with one who underwent OS or LS as the control group (RS:OS=1:1, RS:LS = 1:1 match). Pathological results, morbidity, perioperative recovery, and short-term oncological results were compared between the 3 groups.

**Results:** In RS and LS, the time to first flatus and resumed soft diet and length of hospital stay were significantly shortened compared with OS. Robotic surgery showed better recovery outcomes than LS with regard to time to resumed soft diet and length of hospital stay. The visual analog scale was significantly lower in the RS than in the OS and LS from postoperative days 1 to 5. The voiding problem and circumferential resection margin involvement rate were significantly lower in the RS group than in the OS group. No significant difference in 2-year disease-free survival was observed among the 3 groups.

**Conclusions:** Robotic surgery may be an effective tool in the effort to maximize the advantages of minimally invasive surgery in the management of mid to low rectal cancer.

### POST-OPERATIVE RECOVERY AND PAIN ASSESSMENT



*Study limitations discussed by the authors:* This is a retrospective study. “Although the application of preoperative chemoradiotherapy did not affect the postoperative outcomes in our study population (data not shown), it could be a potential limitation of this study. Another limitation is that disproportion of the surgeon’s experience in each modality was inevitable.” *Financial disclosure:* “The authors declare no conflict of interest.”

## CLINICAL EVIDENCE HIGHLIGHTS: HYSTERECTOMY FOR BENIGN DISEASE

The breadth and depth of literature regarding *da Vinci*® Surgery is extensive. More than 9,500 peer-reviewed studies and reports examining the use of the *da Vinci* Surgical System in various procedures have been published. This section features sample published clinical literature summaries. These summaries should not be seen as a substitute for a comprehensive literature review.

### A COMPARISON OF QUALITY OUTCOME MEASURES IN PATIENTS HAVING A HYSTERECTOMY FOR BENIGN DISEASE: ROBOTIC VS. NON-ROBOTIC APPROACHES

Martino MA, Berger EA, McFetridge JT, et al. *Journal of Minimally Invasive Gynecology*. 2014 May-Jun;21(3):389-93.

#### ABSTRACT

**Study Objective:** To measure procedure-related hospital readmissions within 30 days after discharge for patients who have a hysterectomy for benign disease. Secondary outcome quality measures evaluated were cost, estimated blood loss, length of stay and sum of costs associated with readmissions.

**Design:** Retrospective cohort study (Canadian Task Force classification II-2)

**Setting:** Academic community hospital.

**Patients:** Patients who underwent hysterectomy to treat benign disease from January 2008 to December 2012.

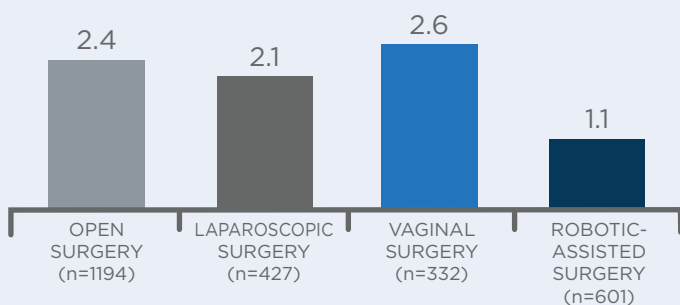
**Interventions:** Patients were grouped according to route of hysterectomy: robotic-assisted laparoscopic hysterectomy (robotic), laparoscopic hysterectomy (laparoscopic), abdominal hysterectomy (open via laparotomy), and vaginal hysterectomy (vaginal).

**Measurements and Main Results:** Inclusion criteria were met by 2554 patients: 601 in the robotic group, 427 in the laparoscopic group, 1194 in the abdominal group, and 332 in the vaginal group. Readmission rates in the robotic cohort were significantly less ( $p < .05$ ) than in non-robotic cohorts: Robotic (1%), laparoscopic (2.5%), open (3.5%), vaginal (2.4%). Estimated blood loss, length of stay, and sum of readmission costs were also significantly less in the robotic cohort ( $p < .05$ ) compared with the other 3 cohorts.

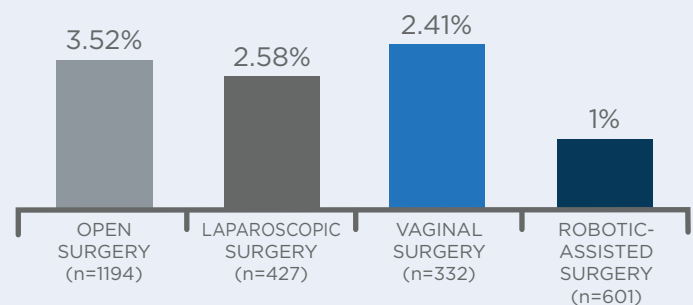
**Conclusion:** Patients who undergo robotic-assisted laparoscopic hysterectomy have a significantly lower chance of readmission <30 days after surgery compared with those who undergo laparoscopic, abdominal (open) hysterectomy, and vaginal approaches. Patients in the robotics cohort also experienced a shorter length of stay, less estimated blood loss, and a cost savings associated with readmissions when compared to non-robotic approaches. Prospective registries describing quality outcomes, total sum of costs including 30 days follow-up, as well as patient-related quality of life benefits are recommended to confirm these findings and determine which surgical route offers the highest patient and societal value.

### QUALITY OUTCOMES MEASURES: HOSPITAL STAY AND READMISSIONS

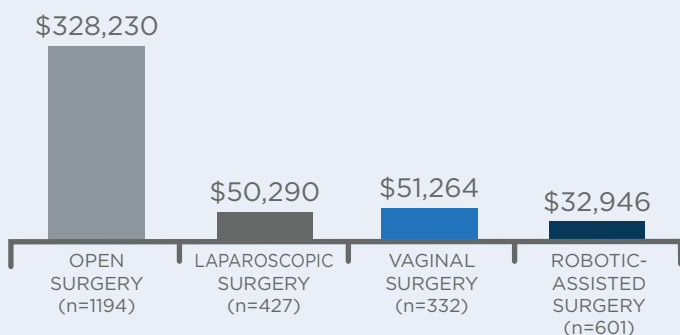
LENGTH OF HOSPITAL STAY (DAYS)



READMISSIONS AT <30 DAYS



TOTAL READMISSIONS COST



$p < 0.05$  Robotic-assisted vs. all non-robotic groups

*Study limitations discussed by the authors:* This is a retrospective study of data from a single institution. "One limitation of the study is inability to account for patients who were readmitted to outside hospitals, although this finding would be expected to be similar for all 4 cohorts."