

FINAL TRANSCRIPT

Thomson StreetEventsSM

SNN - Smith & Nephew American Academy of Orthopaedic Surgeons Analyst Meeting

Event Date/Time: Feb. 14. 2007 / 11:00AM ET

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PRESENTATION

David Illingworth - *Smith & Nephew - COO*

First of all, let me go through the agenda. I'm going to give a brief summary of the Q4 business highlights and then kick off the reconstructive piece of our presentation today. I'm then going to turn it over to Todd Durniak, who is our VP of marketing for the Reconstructive Business.

He, along with a surgeon's perspective on BHR, and a world class athlete/patient perspective on BHR will take us through the reconstructive business. Then Mark Augusti and Dr. Toney Russell will give us a look into the always exciting world of trauma. And wrapping up with a look at our endoscopy business with our newest president, Mike Frazzette.

Okay. In terms of highlights for Q4 '06, group revenue was up 11% to \$771 million, trading profit increased 17% to \$183 million, and we really had good performance across all the divisions. The reconstruction business exited the year with added momentum with 15% growth, and the trauma revenue improved again to 17% growth.

Endoscopy achieved revenue growth of 9%, slightly ahead of the market, and advanced wound management we really think is back on track, although the revenue improvement of 3% really after adjusting for Dermagraft is 7%. So all in all a strong finish to the year. And more importantly, we delivered on the promise of an excellent second half that we made here last year due to the strong lineup of new product introductions.

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Okay, into the reconstructive side. After a slower start to 2006, the reconstructive business really gained momentum and we're riding the wave of the aforementioned product launches that we talked about. Our innovation forms the cornerstone of our share gains. And market expansion we believe will be a key differentiator for companies to grow above market rates.

As you can see from our Q4 growth rate in reconstructive, we outpaced the market in the major segments. This growth continues to be fueled by the rapid expansion of BHR in the U.S. and we are clearly pleased with our success in this area. Our knee business benefited from two important new platforms, the JOURNEY Bi-Cruciate stabilized knee and the Legion Revision system. We are clearly back in our spot as the fastest growing reconstructive company in the market today, a position that we have held 15 of the last 16 quarters.

Before we move into a review of the new products, I think it's important to take some time to point out that while our growth is driven by these new products, we have a -- we feel we have a right to win in the reconstructive market based on the strong clinical performance of our core products. In fact, 2007 marks the tenth anniversary of four of these products, Genesis II, PROFIX, Synergy and, believe it or not, BHR.

The strong clinical performance of these systems, along with our commitment to innovative material like Oxinium and design processes like the very new and exciting LifeMOD computer assisted design, has established a strong foundation for continued product innovation. Our strategic goals are supported with focused investments, such as our sales channel expansion which is critical to support our growing customer base.

And now to provide some more detail on the strategic direction and new products for 2007 and also what to expect at the AAOS, I'd like to bring up Todd Durniak, our VP of global marketing for the reconstructive division.

Todd Durniak - *Smith & Nephew - VP, Reconstructive Division*

All right, thanks, Dave. Good morning, everyone. When we think about 2007 and actually the years beyond, our focus is really going to be about innovative products driving leadership in the active patient segment. The active patient segment is a segment that demands not only wear properties but less restriction on activities, minimally invasive surgery, new implants that allow patients to do more and be more when they're younger and more active.

Our overall goal for the reconstructive division, we want to be the brand preferred by active and informed patients. Around the world these patients are taking control of managing their arthritis pain and getting back to an active lifestyle. Our implants appeal to them, we want to get the message out, we think that's a real strong area for growth in the recon business.

Again, we have a number one global position in resurfacing. We're going to leverage that to bring along a great deal of innovative products here at the Academy to really drive in this active patient market. And we're not alone in Smith & Nephew in dealing with the active patient. Our group has strength that builds some synergy here. I mean we're the number one global arthroscopy company, number three in joint fluid therapy. All of this builds to support our strategic mission; in this early intervention to complete replacement, we have answers for these patients across the board.

So hip demographics and knee demographics are getting younger across the U.S. This is U.S. data from Solutions. Look at where we are with primary hips and knees, 39% of the market is sub-65 these days. And that goes for revision and primary. These patients are looking for different answers than conventional joint replacement provides. So for hips and for knees you see the same sort of demographics. And these segments of the market are growing faster and knee's almost twice as fast as the entire market itself. So it's a very nice space to play in and we believe we have the right to win both for hips and for knees.

2006, we call it our year of innovation. We have had five major product launches. And the good thing is some of these are really just starting to take hold for Smith & Nephew. We've had a full year of Legion revision, we've had a full year of Anthology. But for the EMPERION Hip and the exciting JOURNEY Knee and for BHR in the U.S., we really only had about six months of running

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room. So these things are just starting to get traction for us. And our total sales were up 9%, but 16% of our total is new product sales for growth. That is our growth engine, that's what's driving us forward for the future. We are the fastest growing company in this active space.

So what's new for 2007? I'm really excited to rollout to you the JOURNEY DEUCE Knee. This is a bi-compartmental knee that allows you to treat the medial compartment and the patella-femoral joint, preserving both cruciate ligaments, a first of its kind on the market. You get to keep more of your natural knee and a minimally invasive surgical approach, not just because of incision size, but because you take away less natural tissue. Patients who have this knee say it feels very normal. We're very excited about this. Come by and see it at the booth. We can go into more detail there. But it's new for us this year.

And finally, for us it's been incredibly exciting, at least from the U.S. side here, to launch the Birmingham Hip over the past six months. For us, our launch is ahead of our expectations. We've trained a great deal of surgeons, more than we thought we could, the interest level is high. And this is truly a unique alternative for that active, informed patient. And we'll get a little bit of that patient perspective later on from [Cory Faulk]. But there is high patient and surgeon demand. Surgeons want to learn the technique, they want to be able to provide this to their patients and Dr. Rathjen will speak about that in a moment.

But we know we're not going to be alone in the marketplace, but we believe we have the deepest clinical experience and strongest evidence out there to support our leadership position. So don't take my word for it. I'd like to bring up Kurt Rathjen, who is one of our pioneers in the U.S. launch. He's been implanting the BHR since June. He comes from Dallas in the Dallas Hip & Knee Surgery Clinic. Dr. Rathjen?

Dr. Kurt Rathjen - *Dallas Hip & Knee Surgery Clinic*

Thank you very much, Todd. Thank you all very much for having me here also, Dave. I think I'm a victim of travel in 2007. My flight was two hours late, arriving at midnight last night. I made it; unfortunately my bags didn't make it, so excuse my attire. I think the content of what I'm going to tell you is more important than my appearance, however.

Southern California is where I first heard about hip resurfacing. Hip resurfacing itself is not a new operation. It's been around for 25 or 30 years. And when I was training in the mid 1980s, I came out to a course in Southern California and [Harlan Amsteth] was actually the chairman and they talked about hip resurfacing. But as we would go to [journal clubs] and learn about things, hip resurfacing experience in the United States was really dismal.

Patients did terribly and it was primarily a [bearing surface]. The metal cap was present but it was a polyethylene or plastic shell and the plastic shell was very thin and it would wear out and there'd be tremendous [osteolysis] and patients did much worse with that than they did [from conventional] hip replacement.

But young patients with conventional hip replacement remained a problem. And therefore in the United States, rather than focusing in on hip resurfacing, like [Mr. McMinn] did in the UK, the U.S. surgeons were looking at different bearing surfaces, hence Oxinium, which I think is a wonderful surface, ceramic on ceramic, metal on metal surfaces became more popular.

But about two years ago kind of a coalescence of three things occurred. My wife came home from the nail shop with a People magazine talking about U.S. citizens that were going to India for this new hip procedure called hip resurfacing. They called it new at that time, of course it wasn't.

Second, I was having patients that were emailing me and in this new internet age, patients are very, very educated and savvy. And they were saying, "We understand that not only can you go to India, but you can go to Derek McMinn's place in Birmingham, England and I can have this. When are we going to be able to do this procedure here in the United States?"

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And finally, about that same time Smith & Nephew approached and said, "Would you want to be one of the original core surgeons and go over and visit Derek McMinn and see how he does hip resurfacing and see if that's something that you'd like to bring back to your patients?" And with the coalescence of those three things, I said absolutely, I want to go and meet him.

I went with a colleague from Dallas. We went over and spent two days with Derek McMinn, who is a wonderful educator, a great surgeon. And my hat's off to him for his persistence and years of retrieval studies trying to figure out what worked in metal on metal prostheses in Europe and then also perfecting the metallurgy and the clearance in the particular design that he has stuck with now in his hands for 14 years. And I think that's the biggest winner right now for Smith & Nephew, but also, importantly, for our patients.

And that's what we're all in the business of taking care of, quality of life and taking care of patients is that this now has a proven track record for 14 years, 75,000 hips implanted worldwide. And it does make a difference. I was -- because of my training and experience and the poor U.S. experience with hip resurfacing, I was excited about going, I was excited about learning. I'm not sure where that was going to fit in my algorithm in treating patients.

After having now done my first BHR in June of 2006 and doing my 50th just on Monday morning, I'm a firm believer in that the young active patient, maintaining that extra 2.5 or 3 inches of bone, primarily for when and if that fails because things are going to fail, they're mechanical, is a great advantage to patients. But that's only the beginning. It is more anatomic, it's [load to bone] more normally. We're going to hear from a patient about the wonderful activity levels that they have.

And fortunately to date have had literally zero mechanical complications, which I think is amazing. And I credit Smith & Nephew not only for getting me and my colleague, [Dr. Schubert], an opportunity to go to Birmingham and visit with Derek McMinn about that, but in the way that they have trained their surgeons. Each of my colleagues that goes -- or wants to learn the BHR technology goes to a specific course, we work on cadavers, they have people throughout the country in different regions that will help train us to do this procedure, which is new and different. It's still hip surgery, but it's new and different hip surgery.

I'm delighted with it. It's something that's here to stick. I think it's a winner for Smith & Nephew not only in that it is the most clinically proven hip resurfacing and it's going to stick. For example, I [do morning surgery and then hip surgery], I've done 100 hip surgeries since the launch of BHR. 50% of those, 50 of them have been hip resurfacing.

Mature markets it's 10 or 12%, but what I think that's going to allow Smith & Nephew to do also is, as my colleague, who was not an active Smith & Nephew user, got to know Smith & Nephew and the people and the product and their desire to improve patient's quality of life and know those people he works with on a daily basis and now he's now being introduced to some of their new technology, the JOURNEY knee replacement is now his high demand, high performance knee replacement.

And so all of those things [I do know] and I would agree with what Todd said, this would be an exciting time to work at Smith & Nephew.

Todd Durniak - *Smith & Nephew - VP, Reconstructive Division*

Thank you very much, Dr. Rathjen. There are a lot of unique stories out there for patients in BHR and this one stands out among the rest as being really, really unique. We have -- we're lucky to have Cory Faulk with us. He is a truly accomplished endurance and ultra-distance tri-athlete. I mean over the last 20 years he continues to over-perform his competition. Arthritis really slowed down his career and he received his BHR at the end of '05 and since then has completed a marathon in March and an Ironman World Championship and an Ultraman Hawaii and he's back to full activity and always makes me feel that I need to get out and do a little bit more.

So I'd like to introduce Cory Faulk to you to give you the patient's perspective around BHR.

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Cory Faulk

I understand this is kind of a new and different thing to have the patient's perspective and the good news is as a [world runner] I guess I can't hardly make a mistake, there's no [bar] to compare to. I started with triathlons in the late '70s, back when triathlons started. And I just kind of fell into this sport and I stuck with this sport for almost 30 years now. I actually started doing triathlons down here at Mission Bay in 1979 and first time back in San Diego since then and it looks the same down there.

About 15 years ago I had an encounter with an automobile while I was training and, as is typical of that, the car won. Car one, Cory zero. But I fractured the neck of my femur and they pinned it back together for me, I drew some very talented surgeons, and I made what I thought at that time was a full recovery. It took about a year and a half and a lot of work, but that was it. That ended the whole thing and -- I thought. And they talked to me about the possibility of vascular necrosis and this and that and all this other stuff that could happen to me, but that stuff happens to other people. I was done with the recovery And the rehab and that was it.

About five years later I started having a little bit of difficulty and was at an event in South Africa and I had trouble on the run. And I really couldn't pinpoint anything that was specific to the cycling accident years before. It just was one of those days I must have done something to my hip or whatever. And then about a month after that I had a similar thing going at a Half Ironman over in Hawaii. So I went to my surgeon and he says, "Well, you have a degenerative condition, [AND], starting up in that joint."

So we started looking into options for me then. I was in my late 30s and there really weren't any options for people in their 30s that were active or not active because the total hip replacements at that time had a lifespan of -- estimated lifespan of about 15 years, I think it was, and revisions were awkward and had some success, but they were difficult procedures. They still might be, I'm not a surgeon so I don't know. Any surgery would be difficult for me, I suppose.

But the joint continued to degenerate and I kept competing for years, waiting for the technology to change. A friend of mine had a BHR -- he had a hip resurfacing, it wasn't a BHR, performed as an experimental procedure at UCLA. And unfortunately, I met him about three weeks Post-Op and he was so miserable, he told me, "Don't even consider this as an option." And I didn't put it in the context of him being three weeks Post-Op, I just heard the don't even consider this part.

I continued to limp around for a couple of more years and finally it was really apparent that I either needed to absolutely not just quit competition, but quit walking and wait for the total hip replacement technology to ramp up or risk something as exotic as a hip resurfacing. With a little more exploration, it was pointed out and really the thing that turned it around for me was the idea that this was a starter hip. This wasn't a real hip -- total hip replacement, this was an intermediate step that would buy me time until the technology for the total hip replacement ramped up to where it could be.

And so the worst thing that could happen to me is I would have the pain relieved, I wouldn't be able to compete anymore but at that point it didn't really matter that much, and it would give me a normal level of activity with my children and around my business and other things. I couldn't go to the grocery store, I couldn't tie my shoes, I couldn't do all kinds of really basic things, which any endgame arthritis patient [inaudible] describe all of that, it's all the same for everybody.

So it was an intermediate step. I had almost nothing that I was going to lose. I said goodbye to triathlon in 2005. I went out, I gained entry in the Ironman World Championship and the Ultraman World Championship, which is about three times the Ironman distance for those that like to go a little bit longer. Ironman Revisited, Ultraman Canada, I set up a schedule of events that I could gimp through and say goodbye to all of my friends and colleagues and kind of put a cap on a few decades of triathlon experience. I had surgery scheduled three weeks after the Ultraman world Championship and I fully expected to come out of surgery pain free and barely able to walk and that was going to be the end of it for me. That's what I expected.

Day six Post-Op -- day two Post-Op I was pain free. Day one Post-Op I was on a morphine drip, I was really pain free but [inaudible - background noise]. They took that away and day two I was fine. Day six I was able to do 5K on a -- that's about a little over

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three miles, on a treadmill. Just under three months I did my first road marathon just as kind of a test event to see -- I really wanted to see if the device was going to come apart so that I could go get a total hip replacement and get it over with. The surgeons would have no more excuses, they would have to give me a hip replacement. They couldn't say you're too young or that.

It didn't and so then I really ramped up from there. And I was able at seven months to do the Ironman European Championships over in Germany, at seven and a half months I did Ironman Revisited over in Hawaii, at nine months I did a triple marathon in Memphis, two weeks later I did the Ironman World Championships in [Kuna]. And then I had one of my best performances at the Ultraman World Championships in November less than a year Post-Op.

I had my second best-ever cycling time in that event. And I think that the first best-ever was due to age. I was actually 15 years younger, I think, so that had something to do with it. I don't think it was the hip. So for me it's been a surprising ride. I'm just a little bit over a year Post-Op now and I'm looking forward to doing four Ironman and two Ultraman events this year.

I don't know if this device is going to last at this level. I've been told that I can't wear it out and I've been told by another group that we're happy to tell you how fast it's wearing. I'm participating in studies around that just in case you do. Because it conserves bone it doesn't matter if it wears out in 15 or 20 years for me because I'm back to the level of life that I had always led and I have other options. And if it got me a couple of years pain free, that's great. If it gets me 10 years, that's great. The technology on the other side, the total hip replacement, is going to continue to ramp up and no technology stays stagnant and there will be other options for me in the future.

But I look around, I probably get four emails a week from athletes in the United States asking how can they get this done. And I'm not like -- not in newspaper ads or anything, I'm as hard to get hold of as anybody and they have tracked me down.

And I really see a huge potential here to save a lot of suffering and get a lot of younger people in their 20s, like -- I don't know if Floyd's in his -- he's in early 30s, he's 30-something. Yes, guys that age, guys and gals that age, I know a woman that has two BHR hips that's just -- she's running probably 30 or 40 miles a week. She's right back to her pre-injury level of activity and her life is really good.

So that's a terrific new thing in this area, relieve arthritis in younger people, and that's enough for me. Thanks.

David Illingworth - *Smith & Nephew* - COO

Well, that -- Cory, thank you. Thank you very much. That is amazing stuff and I don't know what you all think about that, but I can tell you for those of you sitting out there who cover us as a company, you need to know that that's why we work so hard in the business we're in because it is just an amazing thing to be able to be in a business that helps people regain their lives.

There's a lot of things you can do in your career and for a living and to be able to do this is pretty special. So thank you very much. I'm glad it's worked out for you. By the way, he did mention -- Cory was talking about [Floyd Landis] who had a Birmingham Hip replacement done shortly after running in the 2006 Tour de France.

Go to the next slide here. Let me wrap up the reconstruction side by saying please come see us in our booth. Come talk to us about our innovation. We're proud of it. Many people that you -- everybody that you're going to bump into at the Smith & Nephew booth is going to be able to talk to you passionately about why they think our innovation model is working better than others. Come see why JOURNEY, Legion, DEUCE and BHR are changing arthroplasty. Come learn why JOURNEY addresses fit and function for males and females. Step into our technology suite to view our active technology and see why we are winning new customers with our core product offerings.

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With that, I'm going to invite Mark Augusti, our president of our trauma and clinical therapies business, to run through what to expect at this year's Academy.

Mark Augusti - *Smith & Nephew - President, Trauma & Clinical Therapy Division*

Thank you, Dave. Good morning, everyone. Welcome back to many of you. For those of you joining us for the first time, glad to have you. As always, love the opportunity to talk about my business and space that we're in.

Trauma and clinical therapies a great space, as many of you know, good solid growth rates, good solid drivers. Just a couple of new things about this slide from last year that you may notice. We talk about outpatient spine now and I'm going to address a little bit of that later in the presentation. Clinical therapies growth continues to be strong. In the U.S. we saw the market of about 9 to 10%. And again, we think we're in a great space.

I'll talk about 2006 briefly. As has been already mentioned, first half of the year was a little tough for the market but we finished very strong in the second half, recording 13% overall growth, a lot driven by clinical therapy and a lot of stuff driven outside the U.S. in joint fluid therapy, which I'll talk a little bit about that later on as well. We expanded our portfolio. PERI-LOC upper extremity to round out the locked plating line, very well received. Launching [more sets] into the field this year. We're expecting really good things in 2007.

A little under the radar but we launched the Meta nail, which is another line extension of TRIGEN, which is a very popular nailing system. We think that's going to deliver well for us this year. And then as I mentioned, in joint fluid therapy in the middle of the year we executed the Q-MED agreement and this drove a lot of sales outside the U.S.

Talk about sales force expansion, we continue to add reps, but what's even more important, as many of you know who follow us, we created the [GDU] in the first quarter and that really involved a lot of sales management changes and building out the sales management channel. And we've completed that obviously in 2006 and we feel like we've got a solid team now going forward in 2007.

One of the product introductions we talked about last year was the TRIGEN INTERTAN system and going after the challenge in hip fractures. We believe this is a huge opportunity, an opportunity to do things a lot better from a clinical standpoint, from a patient standpoint. As we went through significant clinicals and as we launched this product and started to get feedback, we're very bullish about the potential of this product to change people's lives. What we would like to do today is we've invited Dr. Toney Russell, one of the designers of INTERTAN, to talk in more detail about some of the experience of this product and the potential that it has in this segment.

Dr. Toney Russell - *Smith & Nephew - Co-designer Russell-Taylor Nail System*

Thank you, Mark. Good morning. Surprised to be here. I don't get a chance often to talk to people that aren't docs and patients about things we make. So it's kind of a fun thing.

You would think that the most common fractures that we treat would be the one we do the best job on, right? How many of you all have had somebody in your family had a hip fracture? Anybody here? How'd they do? Not too great, right? So the most common fracture we've got is actually one of the real disasters we've got in medicine and it's kind of been a quiet little secret. We've been using the same technology for 50 years. Whether it's a plate or whether it's a nail, it's a single screw device that's round.

What we've done with the INTERTAN system is basically thrown out the old model and actually done a hybridization with hip design technology [inaudible - microphone inaccessible] [applied that to] [inaudible - microphone inaccessible] as well.

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So here's the dismal news. If you have a hip fracture in the United States, this [inaudible - microphone inaccessible], you've got a 25% chance of a full recovery. That's the worst chance I can get from any fracture I treat. 50% of the time will need a cane or walker and I'm in this age group, so I don't like these results at all. What we've done with this is actually changed the whole way we think about fractures and our goal has now been to get the patient up and walking in a pain free [idea], very much like you hear from these recon type doctors.

This was a pivotal case for me. This is something I actually did in 1998. Guy came with a hip fracture. I'd done the one the year before, he'd done okay, and I do a single screw side plate device. This is the standard for 50 years. Whether it's a nail or a plate, it's still a single screw device. [inaudible] comes back and sees me every six weeks to 12 weeks, says, "Hey, it still hurts, I'm not walking too good."

And I give the typical doctor response, "You know we're all getting older, it's pretty tough." At two years he comes back and it's falling apart. And what I see is that the whole femoral neck is gone, the trochanter is broken off and this guy's in a wheelchair. And I've been watching him do this.

So it dawned on me that something is wrong because you shouldn't have an implant that keeps collapsing. We don't do that anywhere else. Well, make a long story short, we went about proving that basically all the current implants that are used are not stable, which is a radical thing to say, we've been doing it for 50 years. This is a poster we had at the [ORS] last year at the meeting and what we've been able to demonstrate with other people's models is that single screw devices actually started eroding through the head as soon as the patient gets up. So the reason they don't move and get going is because they're actually having failure of the implant [of subthreshold amount].

What we've been able to demonstrate with the INTERTAN integrated mechanism is that we actually can put 100,000 cycles of full weight bearing with no cutout. It sounds like a simple thing but it was actually a little hard getting that. This is an example. This is from one of our study sites in Germany. Close to 200 consecutive hips now and this is an osteoporotic 86-year-old lady, a high risk group. She was nailed with the INTERTAN device, three days later she's discharged home, not to a nursing home, and she's walking around her house at three weeks, which is unheard of prior to this time. When we first started seeing these results we didn't quite believe it ourselves. But it's kind of reproduced time after time.

Now, the goal here is functional improvement, but just looking at the mechanical stability of the device, and this is from [Mobandary, give] a little bit of stats in hip fractures, when we started looking at the real healthcare economics for the Baby Boomers coming in, just a slight change, a 10% change in reduction of complications, and they're talking about acute failures leads to \$0.25 billion, [what we're really] targeting is the functional recovery of patients so patients don't expect to do bad and don't expect to go to a nursing home. And so it's going to be an exciting next few years in the hip field.

So thank you very much for the chance of talking to you. Mark?

Mark Augusti - Smith & Nephew - President, Trauma & Clinical Therapy Division

Thank you, Toney. Again, I encourage you to come by the booth and see this very innovative product and talk to us about some of our clinical plans on this.

I want to give you a little update on DUROLANE. As I said, we executed that deal, distribution and joint development deal, in the middle of last year. As you can see, we had fantastic performance, 64% growth outside the U.S. This product is not cleared in the U.S. so soon as we get clearance we'll let you know. But we think this is going to be an attractive product for the younger patient again. This is a single injection product which will more suit people's lifestyles, especially busy active working people that suffer from knee OA who really don't have time to go to the physician for three to five injection regimens. So we think this will be a huge opportunity for us.

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What to watch for in 2007? As always, innovation's the life blood of our business, as we've talked about. We always target to do 25% of new product sales. We [received] 27% last year. We think we'll be able to meet that metric in 2007. I've talked about TRIGEN and PERI-LOC. We're excited about a product that's kind of been under wraps for a while. We're doing a clinical evaluation on a disposable platelet concentrating system. That'll be available in the booth if you want to take a look at it and talk to some people. But we think that should be a very interesting and innovative product.

Clinical therapies, [the two parts] in [inaudible] businesses continue to perform well. We've talked about DUROLANE. And then we talked about the transition from our endoscopy business over to the clinical therapies business of the IDET spine procedure and really the outpatient spine segment. I'll talk a little bit more about that.

Before I do, many of you may have seen the press release this morning. I'm pleased to announce that Randy -- we're partnering with Randy Johnson to be a spokesman for Supartz. He's used the product since 2003 and is an advocate of the joint fluid therapy, believes that it really has enabled him to have an extended career. This is exactly what we talk about when we talk about the younger patients.

Just as a side note, I was in the UK the last couple of weeks when we were finalizing the agreement with Randy and I was talking to some of my UK colleagues how excited I was and this would be big news for the business and they said, "Randy who?" Apparently if it's not David Beckham they just don't care. But we're excited and Randy will be at the booth tomorrow and he'll be giving two talks about his experience with Supartz.

Outpatient spine, I think this is really what clinical therapies business is all about. And I've got to close on this, but this is kind of the leveraging and the working between the business units. And Mike coming on, Mike and I talk about this, Mike Frazzette, who you'll hear from in a second, we thought that it made real sense to try to move this over and leverage the great sales force and sales team that we have in the clinical therapies business. And really also leverage the reimbursement capabilities that we have and that we've invested in.

So I think it's a great story. There's a lot of runway in this business. The market growth for the right kind of patient, this is exciting technology. And really, that's what the clinical therapies kind of business model is about, is really being able to flexibly look at the point of care so when we bring out innovative products, whether it's for licensing acquisitions, business development or internal organic development, where's the right channel to put this through and how do we address that. And really, no other company in the orthopedic space can offer that right now.

There's no company that's got the power of the reconstructive, wound management, arthroscopy businesses, calling into the surgeon specialties, but then combining that with the power of the trauma and clinical therapies business that can go to point of care outside the hospital. And I think that gives us a lot of flexibility in the business and is very historic and we're looking to do new things in that space and IDET is just a good illustrative example of what we can do in this business.

So with that said, I'll close on trauma and clinical therapies. I'd like to introduce my colleague, Mike Frazzette, president of our endoscopy division.

Mike Frazzette - Smith & Nephew - President, Endoscopy Division

Thanks, Mark. Good morning, everybody. As Dave mentioned at the outset, I'm the new guy on the block. I've been with Smith & Nephew since July. prior to that I spent about 23 years in healthcare, 16 of those with Tyco Healthcare.

I'm going to spend the next few minutes and talk about our endoscopy business and I want to start just by mentioning that endoscopy is a little bit of a misnomer. Our business is very focused on arthroscopy or sports medicine, so while endoscopy sounds very grand, we're very focused in on sports medicine as an arthroscopy business under this broader orthopedic banner.

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Our competitive arthroscopic market, which includes [access] resection and repair, is approximately \$2 billion U.S. We're the overall market leader at 23% share followed by Arthrex and Mitek at 19 and 17% respectively. Both of those are primarily repair businesses. Then Stryker and Linvatec at 11 and 9% respectively, both of those companies with portfolios that are similar to ours, both repair as well as some capital offering. And then finally, some smaller niche players like Arthrocare and Arthrotek in [inaudible] and repair.

The key market driver, as you've heard here now all morning, is population demographics, it's longer living, more active people who want to stay active. And they have a preference for minimally invasive surgery. They have shorter recovery times, decreased morbidity and in many case equal or better clinical outcomes.

Other drivers to the business are obviously surgeon training, which, simply stated, is training more surgeons to do minimally invasive arthroscopic procedures, and also the proliferation of ambulatory surgery centers in some of our markets, notably in the U.S., which further drives the development of the sports medicine business. And of course new soft tissue technologies such as our CALAZO Interference Screw for ACL repair, that's not only bioabsorbable but also osteoconductive and we'll talk about that in a minute. So there's technology in materials and innovation as well.

In 2006 we had excellent growth again in the back half which was fueled really by four things. First, we continued to drive our core arthroscopic sports medicine, leading the way in new repair with the launch of CALAZO and also the acquisition of OBI, two bookends of a strategy around innovation and proprietary materials. In addition, we continued our role as a pioneer in hip arthroscopy with the industry's first labral repair device for the hip, our Bioraptor Suture Anchor, as well as our Hip Positioning System.

Number two, I'm pleased to note that we continued to launch new products, well over 100 SKUs last year, so that we now have a 28% Vitality Index, that is 28% of our sales coming from products that had been launched in the last three years. Three, we continued to build on our core resection business by launching a new handpiece with more aggressive blades and burrs, and then fourth and certainly not the least, we continued to invest in surgeon and sales force education at a higher pace than we have in the past and we'll spend even more in 2007 on surgeon education, as we see it as a key driver of this business.

Now, you've heard me speak of a couple of these key product launches in 2006. Just to add a little color around that, CALAZO is not only a resorbable interference screw, but it's osteoconductive as well, which means that over the course of 12 months the screw is resorbed by the body. And compounds within the screw stimulate the natural process of bone formation, which offers obviously a significant advantage to patients as well as clinicians. And we continue to be excited about this product as well as our ability to leverage this material in other joints as we grow our sports medicine business overall.

We launched our Condor Control System and our 660HD Image Management System to give our customers control over their medical devices and surgical images inside and outside of the operating room. And again, we've taken the market leading position in hip arthroscopy with the first labral repair anchor plus our Hip Positioning System, which is a cost effective alternative to fracture tables. It's simple, it's easy to use and it attaches to all standard OR tables.

Soon after our [live in July] we made a number of strategic moves around structure and priorities and these are reflected in our core focus for 2007. And really to sum it up it's about staying closer to our core businesses, really the blocking and tackling around sports medicine and arthroscopy. In addition to that we've primed our new product pipeline to deliver key repair products in the knee, the hip and the shoulder. We're also leveraging some key new products. Our DYONICS 25 Pump and arthroscopic shaver enhance these, for example, to continue to convert competitive accounts and we will do that again this year with the launch of our next generation HD camera system.

I mentioned the continued ramp-up in surgeon education. This is a real driver as we train more arthroscopists procedures that utilize our technologies and help improve their patient outcomes. And all in all, I believe this strategy will and this approach will provide attractive results and value to shareholders.

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Now, in addition to our trauma and recon businesses, AAOS also gives a significant -- is also a significant event for us and the next two slides are designed to give you a glimpse of some of the key areas that we're going to focus on at this meeting. We talked about feeding our pipeline a little bit and to support our market leading position in knee repair, we're launching the ACUFEX Anatomic ACL guide system, which is designed to help surgeons perform an anatomical reconstruction of the knee. There are clinical studies that document 10% more rotational control of the knee after anatomical ACL surgery and the procedure also drives use of our ENDOBUTTON and CALAZO Fixation devices.

We're expanding the CALAZO line to include different screw sizes and thread configurations to [meet adds] demand for this product when using the [B-to-B graph], for example in the repair of the ACL. And through the OBI acquisition we've added polygraph technology [inaudible] for uses of bone void filler here in the U.S. and our TufFit [CD], which is approved to repair cartilage in Europe and in Canada. And then in the fast-growing shoulder repair market, we just launched our KINSA Suture Anchor, which is unique in that it allows for adjusting fixation not by bearing the anchor deeper into the bone but by abducting the suture. It's also easy to use as the suture -- the surgeon does not need to tie knots.

And finally, while most hip procedures are performed in the supine position, that is laying on the back, about 30% of them are done using lateral distraction where the patient is lying on their side. And again, our lateral hip distractor, which we are launching now, provides the greatest range of motion. It's simple, it's easy to use, it's smaller, it's cost effective when you compare it to fracture tables, especially in the ambulatory surgery center market.

And then last but not least, our true HD video platform we will launch this spring and, as it exists today, it will be the first HD system throughout, that is from tip to tail, with color clarity and detail unsurpassed in the marketplace.

So in summary, we're the market leader with great sports medicine brands. We'll continue to focus on our core arthroscopy business. We'll continue to invest in our key revenue drivers. We've got a healthy Vitality Index and a pretty strong pipeline. I would invite all of you to come by and visit us at the booth. Thank you.

Now I'd like to have Dave come up and wrap up.

David Illingworth - Smith & Nephew - COO

Thanks, Mike. Okay, well, thank you to all our guest speakers today. My wrap-up is actually a little bit of housekeeping. First of all, we do invite you to come by the booth. I don't think you'll have any problem finding us, but in case you want to know where we are, the orthopedic reconstructive trauma and clinical therapies business is at booth number 1200, Hall B1, and the endoscopy business booth number 1332, Hall B1.

We are going to take some questions. We'd like to take advantage of the fact that we have a panel of experts here and some rather esteemed guest speakers. And we'd like to focus the questions if possible on products and the strategy and of course anything directed to our guests.

Just as another note, Liz Hewitt is in the back. She is going to be floating around the Academy all week. And if you want to reach out to her, if you want to tweak your financial models at all, feel free to do that. She will be hanging out with all of the reams of paper necessary in order to do that.

So I guess we'll -- I will go ahead and direct the questions from here.

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QUESTIONS AND ANSWERS

Steve Lichtman - *Banc of America - Analyst*

Thanks. Steve Lichtman, Banc of America. Two questions, one for Todd and then one for Dr. Rathjen. Todd, can you give us some of the reasons for outperforming on the surgeon training for BHR? Is it more demand from surgeons than initially thought or is the training going quicker than expected, perhaps maybe a lower learning curve than you would have initially thought?

And then for Dr. Rathjen, how are you determining which patients are indicated for BHR who have good enough [bone stock], et cetera? What is your thinking about ultimately the percent of patients that could fall into that category? Thanks.

Unidentified Company Representative

All right, I'll take the first part of that. I think demand was really high and we ramped up everything we could inside to open up the training pipeline and get as many people through the training sites as possible. So I think it was -- the demand was there and we responded to it by going beyond our original plan, putting more resources towards it and getting more people on those sites to be trained, and clearly not just the UK but Canada and now as we ramp up sites in the U.S. we're able to expand from that for training.

Dr. Kurt Rathjen - *Dallas Hip & Knee Surgery Clinic*

Just to second that, I would agree that demand among our colleagues is tremendous. I mean there's still a few, although one of my good friends is a high volume surgeon in Dallas [inaudible - background noise] institution and was kind of holding back on hip resurfacing [inaudible - microphone inaccessible] Mr. McMinn in the next two or three months. So everybody is interested in this because of [inaudible - background noise] like Cory. And it really comes down to the heart of everyday activity. I mean obviously [inaudible - microphone inaccessible] are incredible, but just the quality of life and enjoying family [inaudible - microphone inaccessible] added bonus for him.

Difficult thing to find those patients and because the world is more Internet savvy and you get a lot of patients that probably aren't the best, the 70-year-old females that come in and want to have the newest, latest, greatest, it's a process of education. We generally get patients 60 and under, but [60s a number]. There's patients that are 55 that look like they're 65 and there's 64-year-old patients [inaudible - microphone inaccessible] look like they're 50 years old. So it's talking to patients, their activity level and then trying to get a handle on their bone quality [inaudible - microphone inaccessible].

There are some studies and I was fortunate to go to the hip resurfacing forum that was in Boston this past year and people are looking at bone density tests and those other things that that remains, as I tell patients, the one downside in hip resurfacing, there is a 1 or 2% incidence of that bone that we maintain fracturing. That's throughout the UK, Europe and now the Australian experience. So there's something out there that we don't get yet but we're trying to get smarter in those[ongoing] studies.

Milton Hsu - *Bear Stearns - Analyst*

Milton Hsu from Bear Stearns. Dr. Rathjen, just a question on the design of the competitive hip resurfacing implants out there. I mean obviously Derek McMinn originally designed the [inaudible - microphone inaccessible]. When that product eventually gets on the market, is there really any difference between the two or is it just the instrumentation [effect]?

Dr. Kurt Rathjen - *Dallas Hip & Knee Surgery Clinic*

I'm a better clinician than engineer, so I can't speak to the specific metallurgy and the clearance, which are two of the things about the [inaudible - microphone inaccessible] hip [surgery] [inaudible]. But as a clinician that takes care of patients, our first

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responsibility is to patients to be really, really hard for me [in surgery] to see that [a] 14 year history [be done] 75,000 done worldwide, and it's not a [inaudible] surgery. It's not [it's collected good] surgeons that they pick for FDA studies. It's done worldwide it's [reproducible]. Well if I am going to use -- I'm a little apprehensible about [inaudible] for surgery. Am I going to use something that has a tried and true [inaudible] record? Or, am I going to use something that hasn't been done as much, whether it be 500 or 5,000 patients? So it's just not the numbers there.

Unidentified Audience Member

I think I want to switch back to a follow-up question for Dr. Rathjen. When you look at hip resurfacing [inaudible - microphone inaccessible] what proportion of the existing hip market do you think could be [substituted] by hip resurfacing and a follow-up after that obviously is what proportion of the young people will not [inaudible - microphone inaccessible] can be treated by hip resurfacing?

Dr. Kurt Rathjen - Dallas Hip & Knee Surgery Clinic

[inaudible - microphone inaccessible] I think except for people that don't adequate bone quality and that's going to -- most young patients, whether male or female are going to have adequate bone quality. Certainly there are [inaudible - microphone inaccessible] are going to want to maintain their bone, [we love to] preserve bone for later procedures [inaudible - microphone inaccessible].

So I think except for that child bearing -- and the other downside in addition to 2% [inaudible - microphone inaccessible] accumulate in the body after a hip resurfacing may increase for a while and there's a [wear-in] phase and then they kind of level out. And it -- we don't know what that [inaudible - microphone inaccessible] but we don't know if there's any deleterious side effects to that. So that needs to be studied.

Women of child bearing age tend to be the one exception to using the metal one, metal bearing surfaces. [inaudible - microphone inaccessible] big heads are better in [inaudible - microphone inaccessible] dislocation rate, which is the one catastrophic complication after hip arthroplasty. They've been used for 14 years, which is more than ceramic on ceramic in the United States, more than U.S. metal on metal, more than Oxinium on improved polyethylene.

And remember, very small changes in either metallurgy or plastic, and I've been around 17 years, long enough to know that some small consequence is thought to be good, that [unintended poor consequences] can affect things. And that's why having a proven track record really makes [inaudible - microphone inaccessible]. I think five years from now most patients will get a [monolithic] metal cup and a big metal head except [inaudible - microphone inaccessible].

Unidentified Audience Member

And a follow-up on that. [inaudible - microphone inaccessible] what proportion of your patients do you actually turn away because they're too young for [permanent hip replacement] [inaudible - microphone inaccessible]?

Dr. Kurt Rathjen - Dallas Hip & Knee Surgery Clinic

A good question. I think -- I don't have [inaudible - microphone inaccessible].

Unidentified Audience Member

Thanks. [inaudible - microphone inaccessible], Morgan Stanley. Question for Todd on hips and knees. It seems like [inaudible - microphone inaccessible] but it seems like the excitement, the promise, the training cycle around the Birmingham Hip had

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some impact potentially on your U.S. knee business just in terms of sales person focus. I'm wondering when we start to see that sort of subside and maybe a rebalancing of your hip and knee performance in the U.S.

And then also as a follow-up, is there anything in particular that you're doing or planning on doing to reaccelerate [inaudible - microphone inaccessible] given the JOURNEY launch last year coming into this year?

Unidentified Company Representative

Well, we are seeing a rebound, we're feeling a rebound in knees right now and it's interesting to see that a lot of the folks we approach with BHR get a chance also to see the JOURNEY technology, so seeing that [pull-through] balance swinging in our favor. And more than half our JOURNEY cases and evaluations are with people that never used a Smith & Nephew product before. So I think that in 2007 we are going to swing that back and that pull-through on the knee side as well.

Unidentified Company Representative

I think there's a very natural -- a very natural moment of inertia that you need to get over when you're launching something of the magnitude of a BHR into a market the magnitude of the U.S. market. And we put a heck of a lot of effort into it and we were very, very focused. And I think that a natural byproduct of that was that we had folks focused on the BHR product, training, the rollout of the product, the training of our own people and I think you're starting to see our folks get a much better balance across all the product breadth right now.

Unidentified Audience Member

And just one follow-up on that in terms of timing, if we think about the JOURNEY was launched about a year ago, Birmingham the second half of last year, is it fair to think that maybe second half of this year we start -- you may be hitting the full stride of JOURNEY and then sort of around the same time or into next year really getting the full stride in Birmingham? Is that the right way to think about it?

David Illingworth - Smith & Nephew - COO

Well, we've got an all-out sprint on Birmingham right now, I can tell you. What do you think, Todd?

Todd Durniak - Smith & Nephew - VP, Reconstructive Division

[inaudible - microphone inaccessible] the major rollout and [sets] really started to hit the market. So both of those things are kind of neck and neck in terms of time in market and our sales force is feeling more comfortable selling that, getting out there with the message and putting more effort around that. And we're still in that full-out sprint with BHR. But we're noticing that those conversations start around JOURNEY, so I think 2007 --

David Illingworth - Smith & Nephew - COO

And we were still growing -- we were still growing the momentum in [Genesis II knees] eight years into that product launch. So these are major platforms that we're talking about and these are major hurdles to get over when you're converting accounts and the stickiness of the surgeons, et cetera. So we're very, very happy with the momentum we have. We think we're on track. There's worse things that can happen to you to be so focused on BHR that you're doing really, really well. And that's kind of where we are right now. So we're going to rebalance it a little bit for sure. It was a good observation.

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Yes?

Unidentified Audience Member

Thank you. [Jared] from Bear Stearns. Mike, can you comment on the current appetite for spending on the hospital side for capital equipment and kind of where you're positioning your HD suite versus competition, Stryker, Olympus, GE? And then on the recon side, Todd, if you could kind of talk about how important it is being the first to market here in hip resurfacing? And Dr. Rathjen, you said you had done 50 in the past six months, 50 BHR procedures. Do you think that's normalized for your -- personally for where you're going?

Mike Frazzette - Smith & Nephew - President, Endoscopy Division

With respect to our HD camera system, we don't expect any significant changes in the hospitals' appetite [inaudible - microphone inaccessible] so it does kind of go up and down around a three year natural cycle [inaudible - microphone inaccessible]. Our product, I would encourage all of you to stop by our booth and see the products and video is one of those things you actually have to experience.

Our product, as the market exists today, will be the first and only true HD from tip to tail. For those of you who have HD television sets at your home, you know if you get something broadcast in HD and you get a box in HD or your satellite system, you get an actual visualization picture in HD. Same thing holds here. Our system is the only system as the market exists today that will be truly HD from tip to tail [inaudible - microphone inaccessible].

Todd Durniak - Smith & Nephew - VP, Reconstructive Division

Okay, to comment on the BHR question being first to market, it's incredibly important to be first to market. We do face competition in all our other markets in the world and we will face it here. The thing that's on our side is we've got a great story and being first to market allows us to tell that story to more people before the marketplace gets crowded with other messages. So we're very excited to be there. We think it's a great responsibility and we're enjoying it.

Dr. Kurt Rathjen - Dallas Hip & Knee Surgery Clinic

I would -- I don't know specific numbers. I would imagine that in every practice it'd be different [inaudible - microphone inaccessible].

Unidentified Audience Member

This is [inaudible] from Merrill Lynch and I have three questions. Can you give us an update on the reimbursement [inaudible - microphone inaccessible] in U.S.?

Secondly, in your digital OR business, would you consider moving into [inaudible]? And then finally, can you talk a little bit about the failure rates that you see in BHR or for BHR in the first six months in the U.S. and it compares to the findings or the data from the UK and Australia?

Todd Durniak - Smith & Nephew - VP, Reconstructive Division

Okay, the first part was around reimbursement in the U.S.

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Unidentified Company Representative

I think it was on IDET.

Unidentified Speaker

All right, I'm sorry.

Todd Durniak - *Smith & Nephew - VP, Reconstructive Division*

[inaudible - microphone inaccessible]

Unidentified Company Representative

[inaudible - microphone inaccessible]

Unidentified Company Representative

And relative to BHR, we're not seeing anything that would alarm us at this point. Still very early in the experience in the U.S. and we'll continue to monitor that pretty closely and as time goes on we'll be able to deliver and talk more about that.

Unidentified Audience Member

[Peter] [inaudible - microphone inaccessible]. A couple of questions, first on hip resurfacing. [inaudible - microphone inaccessible]

Unidentified Company Representative

I would assume that they could use who's ever approved in the marketplace. I think that resurfacing on those, some of the specific instruments may be different from one product to another. Putting a cap on the femoral head rather than [inaudible - microphone inaccessible].

Unidentified Speaker

[inaudible - microphone inaccessible]

Unidentified Audience Member

[inaudible - microphone inaccessible]

Unidentified Company Representative

[inaudible - microphone inaccessible]

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David Illingworth - *Smith & Nephew - COO*

Really nothing to report. It's in process.

Ed Ridley-Day - *Lehman Brothers - Analyst*

Ed Ridley-Day from Lehman Brothers. Just a quick follow-up for Dr. Rathjen in terms of [inaudible - microphone inaccessible] very, very good product there. But have you had any [inaudible - microphone inaccessible] at all from [your hospitals] in terms of how often you can use [inaudible - microphone inaccessible]?

Dr. Kurt Rathjen - *Dallas Hip & Knee Surgery Clinic*

I'm very fortunate I practice in a single hospital that puts zero pressure on me as a surgeon. I'm unique in that I don't have that pressure at all. My understanding is from the hospital that the -- most of these patients are private payers, non-government payers. That's passed on through the payers [inaudible - microphone inaccessible].

David Illingworth - *Smith & Nephew - COO*

Any others? Yes, one more.

Tom Jones - *JPMorgan - Analyst*

Hi. Tom Jones from JPMorgan. Just a quick question for Dr. Rathjen. [inaudible - microphone inaccessible] hip resurfacings you've performed so far, what percentage of those in your experience would you have recommended for [THA] had resurfacing not been available? And of that percentage, how many would have turned it down [inaudible - microphone inaccessible]?

Dr. Kurt Rathjen - *Dallas Hip & Knee Surgery Clinic*

I think every single one of the patients had enough [inaudible - microphone inaccessible] that had they wanted to they would have [inaudible - microphone inaccessible] to his credit kept plugging along and kept going and obviously he found something that works great for him.

David Illingworth - *Smith & Nephew - COO*

Okay, we have time for one more. One more question? All right, well, I think we've got it. Well, thank you very, very much. We'll see you at the booth.

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