CLINICAL INVESTIGATION PLAN

CLINICAL INVESTIGATION TITLE:	A Post-Market Clinical Evaluation of the ReUnion Reversible Fracture (RFX) System
MEDICAL DEVICE:	ReUnion RFX System
DESIGN:	Post-Market, Multicenter, Prospective, Two Arms, Non-Randomized
INDICATIONS:	This study will adhere to the indications and contraindications for the ReUnion RFX System as are detailed in the device's Instructions for Use.
REGULATORY STATUS:	510(k) Clearance received on 23Nov2016
PHASE:	Post-Approval Clinical Investigation
SPONSOR:	Stryker Orthopaedics 325 Corporate Drive Mahwah, NJ 07430
AUTHOR:	Emily Arndt
INVESTIGATORS:	Investigators' information is on file at the Sponsor
MEDICAL EXPERT:	Dr. Stefan Maartense, MD, PhD
COMPLIANCE STATEMENT:	This study will be conducted in compliance with the protocol, International Conference of Harmonisation Good Clinical Practice (ICH-GCP), and all other applicable regulatory requirements, including the retention of essential documents. Investigators will be trained on the study devices and surgical techniques prior to implanting study subjects.
CONFIDENTIALITY STATEMENT:	This protocol contains confidential information and its' use is limited to investigational staff intending to conduct the study, Institutional Review Boards (IRBs) and any others charged with reviewing the study.
VERSION:	2
DATE:	08Aug2018

Approval Page

APPROVERS			
Role	**Name**	**Signature**	**Date**
Medical Expert	Dr. Stefan Maartense	DocuSigned by: Naam ondertekenaar: Stefan Maartense Reden voor ondertekening: Ik keur dit document goed Ondertekentijd: 09-aug-2019 | 01:19 PDT 6D3FDEE7A6924A1FB62AC593A6A40AEC	09-aug-2019 | 1:19 AM PD
Clinical Research Head (CRH)	Georgia Mitchell	DocuSigned by: Georgia Mitchell Signer Name: Georgia Mitchell Signing Reason: I approve this document Signing Time: 12-Aug-2019 | 10:44 AM EDT B2566DB498234B2182378F1BD6240617	12-Aug-2019 | 1 :44 AM ED
Regulatory Affairs (RA)	Heike Gustke	DocuSigned by: Heike Gustke Signer Name: Heike Gustke Signing Reason: I approve this document Signing Time: 12-Aug-2019 | 12:05 AM PDT 9A1F49D7CB6D42EBA4A64A66357BABB9	12-Aug-2019 | 12:05 AM P
Statistician	Claudia Beimel	DocuSigned by: Claudia Beimel Signer Name: Claudia Beimel Signing Reason: I approve this document Signing Time: 19-Aug-2019 | 12:08 AM PDT CF9D5AE352C545BAB2C9FF408F88CDAF	19-Aug-2019 | 12:08 AM P

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1. List of Abbreviations

Acronym	Definition
ADE	Adverse Device Event
AE	Adverse Event
ASES	American Shoulder and Elbow Surgeons
CI	Confidence Interval
CIP	Clinical Investigation Plan
CRF	Case Report Form
eCRF	Electronic Case Report Form
EDC	Electronic Data Capture
HA	Hemi-Shoulder Arthroplasty
ICF	Informed Consent Form
IFU	Instructions for Use
IRB	Institutional Review Board
ITT	Intent-to-Treat
LTFU	Lost to Follow-Up
ORIF	Open Reduction Internal Fixation
PP	Per Protocol
RFX	Reversible Fracture
RSA	Reverse Shoulder Arthroplasty
SADE	Serious Adverse Device Effect
SAE	Serious Adverse Event
SAP	Statistical Analysis Plan
TSA	Total Shoulder Arthroplasty
UADE	Unanticipated Adverse Device Effect

2. Synopsis

Study Title:	A Post-Market Clinical Evaluation of the ReUnion Reversible Fracture (RFX) System
Study Treatment:	ReUnion RFX System
Study Design:	• Post-Market • Multicenter • Prospective • Two arms • Non-Randomized
Objectives	The objective of this clinical investigation is to demonstrate the safety and efficacy/performance of the ReUnion RFX System. Efficacy/performance of the procedure will be measured by the American Shoulder and Elbow Surgeons (ASES) Shoulder Score. Safety of the ReUnion RFX System will be demonstrated through reporting of device-related intraoperative and postoperative Adverse Events (AEs).

Target Population	100 subjects are to be enrolled in this clinical investigation. Enrolled subjects will be assessed at Preoperative, Operative/Discharge, and at 6 Weeks, 6 Months, 12 Months, 24 Months and annually thereafter up to 10 years following the index procedure.
Endpoints	**Primary Endpoint – Arm A (Total Shoulder Arthroplasty / Hemiarthroplasty):** The objective of the clinical investigation is to demonstrate non-inferiority of the ASES Shoulder Score at 24 months postoperative compared to the benchmark literature for Arm A. **Primary Endpoint – Arm B (Reverse Shoulder Arthroplasty):** The objective of the clinical investigation is to demonstrate non-inferiority of the ASES Shoulder Score at 24 months postoperative compared to the benchmark literature for Arm B. **Secondary Endpoints (for both Arm A and B):** Information on the following outcomes will be assessed: • Safety: Incidence of device-related intraoperative and postoperative AEs • Efficacy/Performance: Implant survivorship will be monitored
Inclusion Criteria:	a. Subject is willing to sign the informed consent. b. Subject is willing and able to comply with postoperative scheduled clinical evaluations. c. Subject is male or non-pregnant female and 18 years or older at the time of surgery. d. When used with ReUnion Total Shoulder Arthroplasty (TSA) Humeral & Glenoid components as a Hemiarthroplasty or Total Shoulder Replacement, subject has one or more of the following: • Aseptic necrosis of humeral head • Painful, disabling joint disease of the shoulder resulting from degenerative arthritis, rheumatoid arthritis or post-traumatic arthritis • Proximal humeral fracture and/or dislocation • Clinical management problems where arthrodesis or alternative reconstructive techniques are less likely to achieve satisfactory results • Previous unsuccessful total shoulder replacement, resurfacing or other procedure e. When used with ReUnion RSA Humeral & Glenoid Components as a primary, fracture or revision total shoulder replacement, subject's joint has gross rotator cuff deficiency, a functional deltoid muscle and is anatomically and structurally suited to receive the implant, and subject has one or more of the following: • Painful, disabling joint disease of the shoulder resulting from degenerative arthritis or rheumatoid arthritis • Proximal humeral fracture • Previously failed shoulder joint replacement

Exclusion Criteria:	a. Subject has an active or suspected latent infection in or about the shoulder joint. b. Subject has mental or neuromuscular disorder which would create an unacceptable risk of prosthesis instability, prosthesis fixation failure or complications in postoperative care. c. Subject has bone stock compromised by disease, infection or prior implantation which cannot provide adequate support and/or fixation to the prosthesis. d. Subject has anticipated activities which would impose high stresses on the prosthesis and its fixation. e. Subject is obese such that he/she produces a load on the prosthesis which can lead to failure of fixation of the device or to failure of the device itself. f. Subject has concomitant disease(s) which may significantly affect the clinical outcome. g. For Total Shoulder Arthroplasty and Hemi-Shoulder Arthroplasty: Subject has absent, irreparable or non-functioning rotator cuff and other essential muscles.

3. General Information and Administrative Structure

3.1. SPONSOR

Stryker Orthopaedics
325 Corporate Drive
Mahwah, NJ 07430

3.2. KEY SPONSOR PERSONNEL

Emily Arndt
Study Manager
Role: Clinical Investigation Manager
Email: Emily.arndt@stryker.com
Phone: +1 269 303 7578

Hanna Schlyter
Senior Director Clinical Affairs Trauma & Extremities
Role: Clinical Research Head

Dr. Stefan Maartense, MD, PhD
Role: Medical Expert

3.3. EDC SYSTEM

Name: IBM Clinical Development
Email: icdhelp@us.ibm.com
Phone: +1 888 500 4247

4. Product Information

All components of the ReUnion RFX System have been cleared and approved for sale and use in the United States prior to starting the clinical investigation. 510(k) Clearance was received on 23Nov2016. This system is to be used only for indications for which it has been approved. Please see the approved Instructions for Use (IFU) and Operative Technique manuals for a detailed description of the medical device(s) and instrumentation as well as the intended use information.

Medical device product traceability will be achieved by capturing the implant lot number.

5. Risks and Benefits

This prospective, multicenter clinical investigation is designed to examine the safety and performance of the ReUnion RFX System in accordance with the approved IFU, labelling and instrumentation. The potential risks to subjects are described in the approved IFU and Operative Technique manuals.

Potential benefits resulting for the ReUnion RFX System over other devices and procedures as demonstrated by superior scoring on the outcome survey and positive results on other clinical evaluation measurements would suggest affirmative clinical efficacy.

6. Introduction

Proximal humerus fractures currently represent one of the most difficult surgical procedures in the upper extremity. Besides conservative treatment and open reduction and internal fixation (ORIF) with plates or intramedullary nails, shoulder arthroplasty represents an alternative treatment option for certain indications. Industry currently provides modular options allowing for easy, streamlined intraoperative decision making between anatomical hemiarthroplasty (HA), anatomical total shoulder arthroplasty (TSA) and reverse shoulder arthroplasty (RSA) as well as the option for later conversion or revision utilizing a prior well-fixed humeral stem.

The ReUnion RFX System is indicated for use as a HA, TSA or RSA. It includes a humeral fracture stem component which can be used in conjunction with the ReUnion TSA or ReUnion RSA humeral and glenoid components.

7. Clinical Investigation Design

This investigation is a prospective, multicenter clinical investigation. It is anticipated that a total of one hundred (100) subjects will be enrolled at approximately 5-10 sites. Neither subjects nor investigators are blinded to treatment and the clinical investigation does not include a contemporaneous control. The clinical investigation has been designed to follow the surgeon's standard of care for joint arthroplasty patients, which entails clinical evaluation on a regular ongoing basis, or as needed should the patient become symptomatic in the treated joint. The enrollment period is expected to occur over 20 months.

8. Objective

8.1. PRIMARY ENDPOINT – ARM A (TOTAL SHOULDER ARTHROPLASTY / HEMIARTHROPLASTY (TSA/HA))

Degenerative, rheumatoid or post-traumatic arthritis of the shoulder joint and proximal humerus fractures:

The primary objective of the clinical investigation is to demonstrate non-inferiority of the ASES Shoulder Score at 24 months postoperative compared to the benchmark literature for Arm A. The 24 months mean ASES Shoulder Score result of the RFX System (TSA/HA) will be compared to the pooled postoperative mean estimate of the control group (58.74 points). The pooled standard deviation of the postoperative ASES Shoulder Score result of the benchmark (20.33 points) was used to determine lower limit. The lower maximum acceptable difference (-θ) is 38.41 points (mean of control - θ or 58.74 – 20.33 = 38.41 points).

Based on the underlying distribution of the data and the result of the normality assessment, either the parametric one-sample t-test or the non-parametric one-sample sign test will be used to compare the 24 months postoperative ASES Shoulder Score results of the ReUnion RFX System (TSA/HA) against the value of 38.41 points.

8.2. PRIMARY ENDPOINT – ARM B (REVERSE SHOULDER ARTHROPLASTY (RSA))

Degenerative, rheumatoid or post-traumatic arthritis, and gross rotator cuff deficiency of the shoulder joint and proximal humerus fractures:

The primary objective of the clinical investigation is to demonstrate non-inferiority of the ASES Shoulder Score at 24 months postoperative compared to the benchmark literature for Arm B. The 24 months mean ASES Shoulder Score result of the RFX System (RSA) will be compared to the pooled postoperative mean estimate of the control group (74.48 points). The pooled standard deviation of the postoperative ASES Shoulder Score result of the benchmark (11.08 points) was used to determine the lower limit. The lower maximum acceptable difference (-θ) is 63.40 points (mean of control - θ or 74.48 – 11.08 = 63.40 points).

Based on the underlying distribution of the data and the result of the normality assessment, either the parametric one-sample t-test or the non-parametric one-sample sign test will be used to compare the 24 months postoperative ASES Shoulder Score results of the ReUnion RFX System (RSA) against the value of 63.40 points.

8.3. SECONDARY ENDPOINTS (FOR BOTH ARM A AND B)

In addition to the principal endpoint, information on the following outcomes will be assessed up to 10 years after the index procedure:

- Safety: Incidence of device-related intraoperative and postoperative AEs
- Efficacy/Performance: Implant survivorship will be monitored

9. Selection of Clinical Investigation Population

Subjects participating in this clinical investigation will be recruited from the investigator's standard patient population. Subjects will be enrolled onto the study by rolling enrollment until approximately 100 target patients are enrolled. All patients will be evaluated for clinical investigation participation based on the eligibility criteria listed below.

9.1. INCLUSION CRITERIA

a. Subject is willing to sign the informed consent.
b. Subject is willing and able to comply with postoperative scheduled clinical evaluations.
c. Subject is male or non-pregnant female and 18 years or older at the time of surgery.

d. When used with ReUnion TSA Humeral & Glenoid components as a Hemiarthroplasty or Total Shoulder Replacement, subject has one or more of the following:

- Aseptic necrosis of humeral head
- Painful, disabling joint disease of the shoulder resulting from degenerative arthritis, rheumatoid arthritis or post-traumatic arthritis
- Proximal humeral fracture and/or dislocation
- Clinical management problems where arthrodesis or alternative reconstructive techniques are less likely to achieve satisfactory results
- Previous unsuccessful total shoulder replacement, resurfacing or other procedure

e. When used with ReUnion RSA Humeral & Glenoid Components as a primary, fracture or revision total shoulder replacement, subject's joint has gross rotator cuff deficiency, a functional deltoid muscle and is anatomically and structurally suited to receive the implant, and subject has one or more of the following:

- Painful, disabling joint disease of the shoulder resulting from degenerative arthritis or rheumatoid arthritis
- Proximal humeral fracture
- Previously failed shoulder joint replacement

9.2. EXCLUSION CRITERIA

a. Subject has an active or suspected latent infection in or about the shoulder joint.

b. Subject has mental or neuromuscular disorder which would create an unacceptable risk of prosthesis instability, prosthesis fixation failure or complications in postoperative care.

c. Subject has bone stock compromised by disease, infection or prior implantation which cannot provide adequate support and/or fixation to the prosthesis.

d. Subject has anticipated activities which would impose high stresses on the prosthesis and its fixation.

e. Subject is obese such that he/she produces a load on the prosthesis which can lead to failure of fixation of the device or to failure of the device itself.

f. Subject has severe concomitant disease(s) which may significantly affect the clinical outcome.

g. For Total Shoulder Arthroplasty and Hemiarthroplasty: Subject has absent, irreparable or non-functioning rotator cuff and other essential muscles.

9.3. WITHDRAWAL CRITERIA

If during the clinical investigation a subject must be prematurely withdrawn, then the procedures outlined in this section must be followed. These procedures should not interfere with the initiation of any new treatments that are necessary to treat a subject's condition. Information on all withdrawn subjects will be documented.

Subjects may be withdrawn from the clinical investigation for any of the following reasons:

i. Subject Withdrawal: A subject may voluntarily withdraw from the clinical investigation at any time and for any reason. The subject should be asked when possible, and without any form of coercion, the reason for his/her decision. If the participant withdraws from the clinical investigation completely, then data collected up until the point of withdrawal will be included in the final analysis.

ii. Lost to Follow-Up (LTFU): A subject will be considered LTFU after all reasonable efforts have been made to contact the subject and request his/her continued participation in the clinical investigation. All attempts to contact the subject must be documented and should include at least two attempts to contact the subject by phone and one attempt via a certified letter. Data collected up until the point where the subject is LTFU will be included in the final analysis.

iii. Removal of Device or AE/Incident: The discontinuation of a subject's participation in the clinical investigation due to the removal of the ReUnion RFX System or AE/incident that prohibits his/her continued participation must be fully explained. All available information concerning the removal of the device or AE/incident should be provided. Data collected up until the point of removal or AE/incident will be included in the final analysis.

iv. Death: The discontinuation of a subject's participation in the clinical investigation due to death must be fully explained. All available information concerning the death or AE should be provided. Removal of a subject from continued follow-up in the clinical investigation due to death will not be considered a device failure unless the death is directly caused by, or attributable to, the ReUnion RFX System. Data collected up until the point of death will be included in the final analysis.

v. Other: A subject may be withdrawn by the investigator if he/she believes it is in the best interest of the subject, or if it is determined by the IRB that a subject's continued participation in the clinical investigation represents an unacceptable risk to the subject. The Sponsor must be notified immediately if this occurs. All data collected up until the point of withdrawal or IRB determination will be included in the final analysis.
A subject may also be withdrawn if the subject is non-compliant with the clinical investigation procedures or visits, or if a selection criteria violation is noted after the subject received the clinical investigation treatment and it is determined that the subject should be discontinued. All data collected up until the point of withdrawal will be included in the final analysis.

10. Clinical Investigation Evaluations, Procedures and Assessments

10.1. METHOD OF ASSIGNING SUBJECTS

No specific methods (e.g. randomization, blinding, or stratification) for assigning subjects are used in this clinical investigation plan (CIP). Consecutive subjects at each site meeting all the eligibility criteria will be enrolled in this clinical investigation.

10.2. PROCEDURES

Subjects in the clinical investigation will undergo placement of the ReUnion RFX System. Please see the approved Instructions for Use and Operative Technique Manuals for a detailed description of the medical device(s) and instrumentation, intended use information and associated risk. Any additional clinically indicated procedures are permitted as deemed necessary by the clinical investigation investigator.

10.3. FOLLOW-UP EVALUATIONS

Subjects in this clinical investigation will be evaluated at Preoperative, Operative/Discharge, and at 6 Weeks (4 weeks – 8 weeks), 6 Months (24 weeks – 28 weeks), 12 Months (48 weeks- 56 weeks), 24 Months (100 – 108 weeks) and annually thereafter. The follow-up evaluations will include assessment of device-related AEs/incidents, radiographs and ASES Shoulder Score.

Investigative site personnel will contact subjects prior to their scheduled follow-up evaluations to encourage compliance with clinical investigation visits and participation.

If a subject misses a visit and is outside of the visit window, every effort should be made to collect data instead of noting the visit as missed.

10.4. SCHEDULE OF EVENTS

Assessment	Pre-Operative	Operative/ Discharge	6 Weeks [a, b] (+/- 2 weeks)	6 Months [a, b] (+/- 3 weeks)	12 Months [a, b] (+/- 4 weeks)	24 Months [a, b] (+/- 4 weeks)	Annually [b] (+/- 4 weeks)
Informed Consent	X						
Demographics & Medical History	X						
Inclusion/Exclusion	X						
Physical Exam	X		X[c]	X[c]	X[c]	X[c]	X[c]
Surgical Procedure		X					
ASES Shoulder Score	X		X[d]	X[d]	X [d]	X [d]	X [d]
Image Evaluation [e, f]	X	X	X	X	X	X	X
Subject Disposition [g]			X	X	X	X	X
	Device-Related AEs/Incidents & Reoperations will be collected throughout the course of the clinical investigation.						
	a. Follow-up visit schedule to reflect Institution's Standard of Care practices b. If the subject misses a visit and is outside of the visit window, then every effort should be made to collect data instead of noting visit as missed. Visit windows are calculated from index event, and not from previous visit. c. Evaluation may be collected when subject presents in-clinic for study visit. d. Evaluation can be collected via phone. e. Radiograph collection should follow Institution's Standard of Care practices and no additional x-rays should be made for study purposes. f. CT scans may be collected if part of Institution's Standard of Care practices. g. Subject Disposition assessment will occur at any time point for subject withdrawal prior to the completion of the clinical investigation.						

Table 1: Schedule of Events

11. Statistical Methods

By clinical investigation arm, the 24 months postoperative results for subjects implanted with the ReUnion RFX System will be compared to a historical group and results reported by respective clinical outcome data in the scientific literature. The benchmark sources and values will serve as the control group for the ReUnion RFX System subjects. Hypotheses are developed for each of the two clinical investigation arms.

The Statistical Analysis Plan (SAP) lists all variables/questions within this clinical investigation. Therefore, no additional "evaluation" chapter is required nor needed for this CIP.

Data will be captured via IBM Clinical Development electronic data capture (EDC) system and statistical analysis will be performed using IBM SPSS. All statistical hypotheses tests will be with confidence levels (1-α) of 95% and power (1-β) of 80%. The significance level (α) is 0.05 and the beta-value (β) is set to 0.20. Therefore, p-values ≤ 0.05 will indicate statistical significance.

Results will be presented using summary tables and optionally supported by graphs. For detailed information per variable, see SAP.

The primary endpoint of the clinical investigation is to demonstrate non-inferiority of the device to the selected literature controls (benchmark), as measured by the ASES Shoulder Score at 24 Months post-operative.

11.1. DETERMINATION OF SAMPLE SIZE

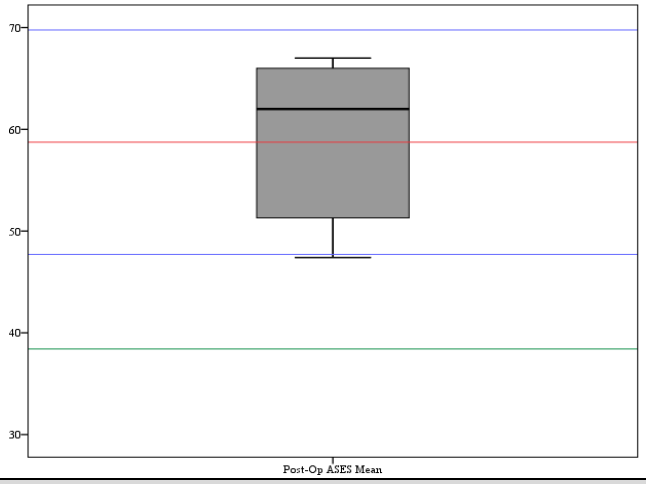
The determination of sample size is based on benchmark sources and values.

11.1.1. Sample Size Justification - Arm A (TSA/HA)

Benchmark and Objectives for Clinical Investigation				
Endpoint	Non-inferiority (equal or better) of the ASES Shoulder Score in relation to the officially cleared indications in comparison to respective clinical outcome data in the scientific literature. Meta-analysis by Shukla et. al., 2016 [1]			
Estimated drop-out rate	56% (confirmed by Medical Expert, see Cuff et al. [2])			
Benchmark Sources & Values ASES [points] for Arm A (TSA/HA) Values from Shukla et. al used that were given for Hemiarthroplasty				
Source		**Mean**	**Std. Dev.**	**Comments**
No.	**Title**			
1	Sebastia-Forcada, 2014 [3]	N/A	N/A	No ASES score
2	Baudi, 2014 [4]	51.3	25.4	
3	Chalmers, 2014 [5]	66.0	31.0	
4	Cuff, 2013 [6]	62.0	14.0	
5	Garrigues, 2012 [7]	47.4	12.75	
6	Young, 2010 [8]	67.0	18.5	
7	Gallinet, 2009 [9]	N/A	N/A	No ASES score
Identified Cleared Indications (Arm A & B)				
No.	**Indication**			
1	Aseptic necrosis of the humeral head			
2	Painful, disabling joint disease of the shoulder resulting from degenerative arthritis, rheumatoid arthritis or post-traumatic arthritis			
3	Proximal humeral fractures and/or dislocation			
4	Clinical management problems where arthrodesis or alternative reconstructive techniques are less likely to achieve satisfactory results			
5	Revision of previous unsuccessful total shoulder replacement, resurfacing or other procedure			
Explorative Analysis - ASES (single group) - for Arm A (TSA/HA)				
Acceptance Criteria				
Confidence Interval (CI)			0.95 (95%) two-sided	
Software Used			IBM SPSS V20	

Descriptives

			Statistic	Std. Error
Post-Op ASES Mean	Mean		58,7400	3,97185
	95% Confidence Interval for Mean	Lower Bound	47,7124	
		Upper Bound	69,7676	
	Median		62,0000	
	Std. Deviation		8,88133	
	Minimum		47,40	
	Maximum		67,00	
	Interquartile Range		17,15	
Post-Op ASES Std.Dev.	Mean		20,3300	3,46719



Red line: Pooled mean ASES

Blue lines: 95% CI of pooled mean ASES

Black line: Pooled median pooled ASES

Box: Interquartile Range

Green Line: Pooled mean ASES minus std. dev. ASES

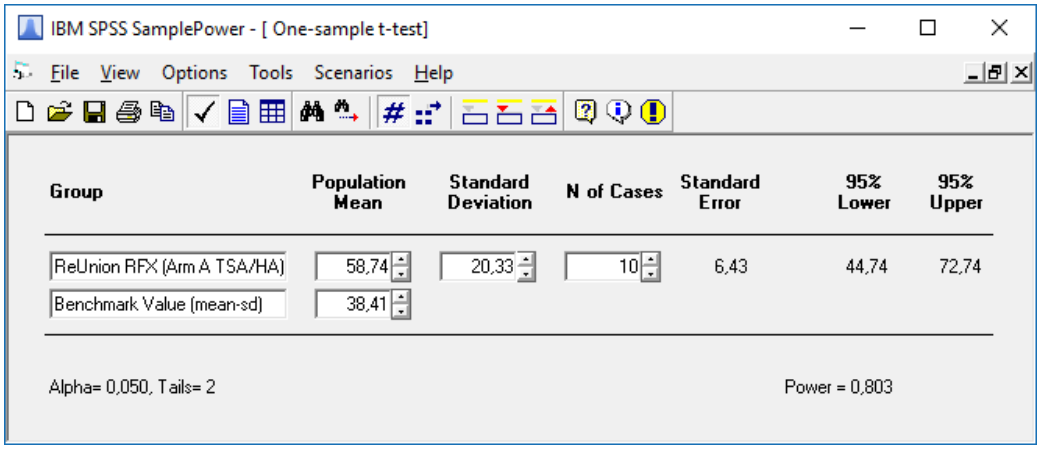
58.74 – 20.33 = **38.41 points**

Acceptance Criteria for Sample Size Calculation		
Significance Level (α)	0.05 (5%)	
Power (1-β)	0.80 (80%)	
Confidence Interval (CI)	0.95 (95%)	
Tails	2	
Path	Non-inferiority – ReUnion RFX Arm A (TSA/HA) (A) ≥ Benchmark (B, explorative analysis in this document)	
Hypotheses Pair	Null (H_0)	A – B < -θ
	Alternative (H_1)	A – B ≥ -θ
Benchmark Timepoint	24 months postoperative	
Benchmark no. of sources	5	
Benchmark Mean	**58.74** (pooled mean ASES [points])	
Benchmark Std. Dev.	**20.33** (pooled std. dev. ASES [points])	
Benchmark Value Non-Inferiority Margin (-θ)	Pooled mean ASES minus pooled std. dev. ASES **58.74 – 20.33 = 38.41 points**	
Software Used	IBM SPSS Sample Power V3.0	

IBM SPSS Sample Power Output

One goal of the proposed clinical investigation is to test the null hypothesis that the population mean is 58.74 points. The criterion for significance (alpha) has been set at 0.05. The test is 2-tailed, which means that effects in both directions will be interpreted. With the proposed sample size of 10 cases, the clinical investigation will have power of 80.3% to yield a statistically significant result. This computation assumes that the population from which the sample will be drawn has a mean of 58.74 points with a standard deviation of 20.33 points. The observed value will be tested against a theoretical value (constant, non-inferiority margin) of 38.41 points.

IBM SPSS Sample Power Output – Screenshot



Estimated overall drop-out rate is 56% which leads to the requirement of enrolling an additional 6 subjects into the clinical investigation.

Sample Size	**Overall number of subjects to be enrolled: 16 subjects (rounded up to 20 subjects)**
Overall Sample Size (multiplied by number of indications = 5)	**100 subjects**

Table 2a: Sample Size Justification Arm A (TSA/HA)

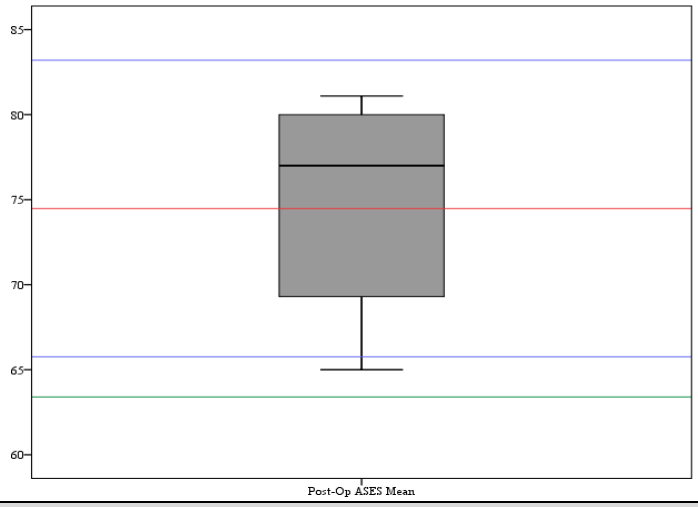
11.1.2. Sample Size Justification - Arm B (RSA)

Benchmark and Objectives for Clinical Investigation				
Endpoint	Non-inferiority (equal or better) of the ASES Shoulder Score in relation to the officially cleared indications in comparison to respective clinical outcome data in the scientific literature. Meta-analysis by Shukla et al., 2016 [1]			
Estimated drop-out rate	56% (confirmed by Medical Expert, see Cuff et al. [2])			
Benchmark Sources & Values ASES [points] for Arm B (RSA)				
Source		**Mean**	**Std. Dev.**	**Comments**
No.	**Title**			
1	Sebastia-Forcada, 2014 [3]	N/A	N/A	No ASES score
2	Baudi, 2014 [4]	69.3	25.4	
3	Chalmers, 2014 [5]	80.0	11.0	
4	Cuff, 2013 [6]	77.0	3.75	
5	Garrigues, 2012 [7]	81.1	3.25	
6	Young, 2010 [8]	65.0	12.0	
7	Gallinet,2009 [9]	N/A	N/A	No ASES score
Identified Cleared Indications (Arm A & B)				
No.	**Indication**			
1	Aseptic necrosis of the humeral head			
2	Painful, disabling joint disease of the shoulder resulting from: degenerative arthritis, rheumatoid arthritis, or post-traumatic arthritis			
3	Proximal humeral fractures and/or dislocation			
4	Clinical management problems where arthrodesis or alternative reconstructive techniques are less likely to achieve satisfactory results			
5	Revision of previous unsuccessful total shoulder replacement, resurfacing or other procedure			
Explorative Analysis - ASES (single group) - for Arm B (RSA)				
Acceptance Criteria				

Confidence Interval (CI)	0.95 (95%) two-sided
Software Used	IBM SPSS V20

Descriptives

			Statistic	Std. Error
Post-Op ASES Mean	Mean		74,4800	3,14124
	95% Confidence Interval for Mean	Lower Bound	65,7585	
		Upper Bound	83,2015	
	Median		77,0000	
	Std. Deviation		7,02403	
	Minimum		65,00	
	Maximum		81,10	
	Interquartile Range		13,40	
Post-Op ASES Std.Dev.	Mean		11,0800	4,00595



Red line: Pooled mean ASES

Blue lines: 95% CI of pooled mean ASES

Black line: Pooled median pooled ASES

Box: Interquartile Range

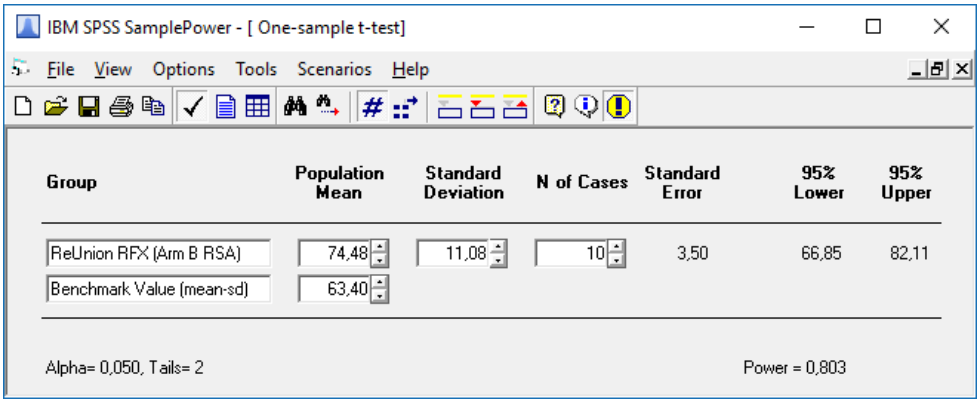
Green Line: Pooled mean ASES minus pooled std. dev. ASES

74.48 – 11.08 = **63.40 points**

Acceptance Criteria for Sample Size Calculation		
Significance Level (α)	0.05 (5%)	
Power (1-β)	0.80 (80%)	
Confidence Interval (CI)	0.95 (95%)	
Tails	2	
Path	Non-inferiority – ReUnion RFX Arm B (RSA) (A) ≥ Benchmark (B, explorative analysis in this document)	
Hypotheses Pair	Null (H_0)	A – B < -θ
	Alternative (H_1)	A – B ≥ -θ
Benchmark Timepoint	24 months postoperative	
Benchmark no. of sources	5	
Benchmark Mean	**74.48** (pooled mean ASES [points])	
Benchmark Std. Dev.	**11.08** (pooled std. dev. ASES [points])	
Benchmark Value Non-Inferiority Margin (-θ)	Pooled mean ASES minus pooled std. dev. ASES **74.48 – 11.08 = 63.40 points**	
Software Used	IBM SPSS Sample Power V3.0	

IBM SPSS Sample Power Output

One goal of the proposed clinical investigation is to test the null hypothesis that the population mean is 74.48 points. The criterion for significance (alpha) has been set at 0.05. The test is 2-tailed, which means that effects in both directions will be interpreted. With the proposed sample size of 10 cases, the clinical investigation will have power of 80.3% to yield a statistically significant result. This computation assumes

<table>
<tr><td colspan="2">that the population from which the sample will be drawn has a mean of 74.48 points with a standard deviation of 11.08 points. The observed value will be tested against a theoretical value (constant, non-inferiority margin) of 63.40 points.</td></tr>
<tr><td colspan="2">IBM SPSS Sample Power Output – Screenshot
 

Estimated overall drop-out rate is 56% which leads to the requirement of enrolling an additional 6 subjects into the clinical investigation.</td></tr>
<tr><td>Sample Size</td><td>Overall number of subjects to be enrolled: 16 subjects (rounded up to 20 subjects)</td></tr>
<tr><td>Overall Sample Size (multiplied by number of indications = 5)</td><td>100 subjects</td></tr>
</table>

Table 2b: Sample Size Justification (RSA)

In conclusion, the calculated number of subjects to be enrolled (10) plus the estimated overall drop-out rate of 56% predicts enrollment of 16 subjects (rounded up to 20) per indication. Since the five cleared indications and the proposed sample sizes are identical for the two clinical investigation arms, the sample size of one indication (n=20) will be multiplied by five to reflect the total underlying subject population adequately. As a result, an enrollment target of 100 subjects in total will be aspired (ideally, but not necessarily, composed with 20 subjects per indication).

11.2. ANALYSIS POPULATIONS

It is expected during this clinical investigation only one population for ReUnion RFX System per arm will exist and all subjects will be analyzed "Per Protocol" (PP). However, it cannot be fully avoided that in theory subjects might need to be excluded from the PP population. In this occasion, there will be two groups being fully analyzed to ensure transparency and avoid bias.

The groups are defined as follows:

- **Intent-to Treat Population**

  The Intent-to-Treat (ITT) Population is defined to be all enrolled subjects. An enrolled subject is a subject that has signed informed consent, all screening procedures have been successfully completed, is eligible and can receive treatment. The ITT population will not be analyzed for the annual reports and will only be included in the final report.

- **Per Protocol Population**

  The PP Population is defined to be all subjects in the ITT Population with no major protocol violations. The protocol deviations that will exclude a subject are as follows:

  - The subject does not receive the ReUnion RFX System

- The subject does not meet all eligibility criteria
- The subject has a protocol deviation that is considered likely to affect subject outcomes.

After the clinical investigation has been completed, a review of the data will be conducted to determine which subjects are to be excluded from the PP population.

11.3. ANALYSIS AND EVALUATION

11.3.1. Statistical Analysis

Evaluation elements are defined as the questions on the CRF/eCRF. The SAP lists all evaluation elements and secondary elements which will be based on calculations between two or more evaluation elements.

All quantitative variables, including those based on calculations (secondary elements), will be analyzed with a case summary evaluation before the detailed characteristics and parameters can be evaluated. A case summary contains a listing of the number of valid cases/values, missing cases/values (if any) and total cases/values in the specific analysis. In general, as central position parameter for quantitative variables the mean, median and mode will be analyzed. As variation parameter the standard deviation, 95% confidence interval of the mean, interquartile range and range (based on maximum and minimum) will be calculated. All quantitative variables will be assessed for normality using the Shapiro-Wilk test. For optional visualization of quantitative variables, box-and-whisker plots will be used. Additional analyses like skewness and kurtosis measures or standard errors are optional also.

All qualitative variables, including those based on summaries (secondary elements), will be analyzed listing the proportions, frequencies, column and row totals, and missing proportion, if any.

The SAP reflects this approach and specifies the variables characteristics (quantitative or qualitative) in detail together with the related analysis strategy. This also includes calculation and summaries based on primary elements and the required analysis.

11.3.2. Primary Analysis / Endpoint

The objective of the clinical investigation is to demonstrate the non-inferiority (equal or better) of the ASES Shoulder Score in relationship to the officially cleared indications in comparison to respective clinical outcome data in the scientific literature.

Data collection of ASES Shoulder Score will be collected according to the schedule in Table 1, Schedule of Events. This will be repeated annually in all subjects who have the prosthesis with full or partial implant survival (including all subjects without removal of all endo-prosthesis components).

The 24 months postoperative results for subjects implanted with ReUnion RFX System will be compared to a historical group and results reported by respective clinical outcome data in the scientific literature.

Higher ASES Shoulder Score results are linked to better subject results and vice versa.

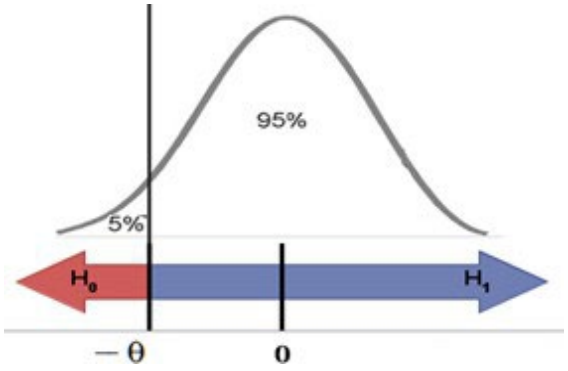
The clinical investigation endpoint is non-inferiority to the control, meaning the clinical investigation result should be equal or better than the control. In this clinical investigation, an equal or better ASES Shoulder Score result means equal or more (≥). As only results from samples will be captured, results are mostly estimates of the true population parameter. These

estimates vary by a certain area, where it is expected that the true population parameter falls within. Based on this, it is required to specify a lower limit for the acceptable difference or zone of indifference, denoted as -θ.

Hypotheses are developed to allow for a comparison of the 24 months postoperative ASES Shoulder Score effectiveness/performance between the two underlying populations. The 24 months post-operative ASES Shoulder Score is the primary endpoint of this clinical investigation. Hypothesis tests will be one-sided with a significance level α of 5%.

Table 3a: Arm A (TSA/HA)

Hypothesis	**Equations**	**Interpretation**
Null (H_0)	$A - B < -\theta$ ReUnion RFX System (TSA/HA) – Control (Benchmark) < -θ	Central tendency of A is inferior to the central tendency of B.
Alternative (H_1)	$A - B \geq -\theta$ ReUnion RFX System (TSA/HA) – Control (Benchmark) ≥ -θ	Central tendency of A is non-inferior to the central tendency of B.



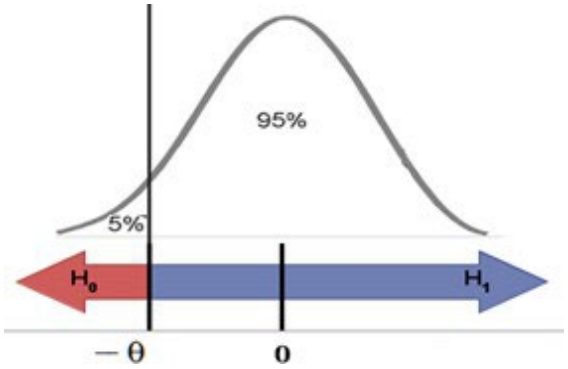
Possible Evidence (p)	**Possible Decisions**	**Possible Conclusions – ASES score**
p-value > α (0.05)	Fail to reject null hypothesis (H_0)	ReUnion RFX System (TSA/HA) < Control (Benchmark) Insufficient evidence to reject the null hypothesis (H_0: A – B < -θ) at the pre-determined significance level of 5%.
p-value ≤ α (0.05)	Reject null hypothesis (H_1)	ReUnion RFX System (TSA/HA) ≥ Control (Benchmark) Sufficient evidence to reject the null hypothesis (H_0: A – B < -θ) at the pre-determined significance level of 5%.

The primary objective of the clinical investigation is to demonstrate non-inferiority of the ASES Shoulder Score at 24 months post-operative compared to the benchmark literature for Arm A. The 24 months mean ASES Shoulder Score result of the RFX System (TSA/HA) will be compared to the pooled postoperative mean estimate of the control group (58.74 points). The pooled standard deviation of the post-operative ASES Shoulder Score result of the benchmark (20.33 points) was used to determine lower limit. The lower maximum acceptable difference (-θ) is 38.41 points (mean of control - θ or 58.74 – 20.33 = 38.41 points).

Based on the underlying distribution of the data and the result of the normality assessment, either the parametric one-sample t-test or the non-parametric one-sample sign test will be used to compare the 24 months postoperative ASES Shoulder Score results of the ReUnion RFX System (TSA/HA) against the value of 38.41 points.

Table 4a: Arm B (RSA)

Hypothesis	**Equations**	**Interpretation**
Null (H_0)	$A - B < -\theta$ ReUnion RFX System (RSA) – Control (Benchmark) < -θ	Central tendency of A is inferior to the central tendency of B.
Alternative (H_1)	$A - B \geq -\theta$ ReUnion RFX System (RSA) – Control (Benchmark) ≥ -θ	Central tendency of A is non-inferior to the central tendency of B.



Possible Evidence (p)	**Possible Decisions**	**Possible Conclusions – ASES score**
p-value > α (0.05)	Fail to reject null hypothesis (H_0)	ReUnion RFX System (RSA) < Control (Benchmark) Insufficient evidence to reject the null hypothesis (H_0: $A - B < -\theta$) at the pre-determined significance level of 5%.
p-value ≤ α (0.05)	Reject null hypothesis (H_1)	ReUnion RFX System (RSA) ≥ Control (Benchmark) Sufficient evidence to reject the null hypothesis (H_0: $A - B < -\theta$) at the pre-determined significance level of 5%.

The primary objective of the clinical investigation is to demonstrate non-inferiority of the ASES score at 24 months post-operative compared to the benchmark literature for Arm B. The 24 months mean ASES Shoulder Score result of the RFX System (RSA) will be compared to the pooled postoperative mean estimate of the control group (74.48 points). The pooled standard deviation of the post-operative ASES Shoulder Score result of the benchmark (11.08 points) was used to determine the lower limit. The lower maximum acceptable difference (-θ) is 63.40 points (mean of control - θ or 74.48 – 11.08 = 63.40 points).

Based on the underlying distribution of the data and the result of the normality assessment, either the parametric one-sample t-test or the non-parametric one-sample sign test will be used to compare the 24 months postoperative ASES Shoulder Score results of the ReUnion RFX System (RSA) against the value of 63.40 points.

11.3.3. Secondary Endpoints

The incidence of device-related AEs and implant survivorship will be assessed up to ten years after the index procedure and monitored through collection and analyses. These analyses will be part of the annual and final reports.

Furthermore, time to (earliest) device-related AEs will be analyzed as well. For analysis of the time to the (earliest) device-related AEs as well as the time to secondary procedure (revision, removal, reoperation), the Kaplan-Meier method will be used. The time between surgery and the last available assessment will be used together with the time between date of surgery and the date of secondary procedure. Considered variables, the level of measurement and the planned analysis steps are listed in detail in the SAP.

11.3.4. Additional Analyses

Additional analyses are outlined in the subsequent sections. Analysis details (variables, level of measurement, planned steps) are listed in-depth in the SAP.

- **Mortality**
  For analysis of the time to death or mortality, the Kaplan-Meier method will be used. The times between surgery and the last available assessment will be used together with the times between date of surgery and the date of death. This analysis will be part of the annual and final reports.

- **Total ASES Shoulder Score – Within subject changes by visit**
  The within subject score changes of the ASES Shoulder Score from visit to visit will be analyzed to help identify the changes on the subject level. This analysis will be part of the annual and final reports.

11.4. MISSING DATA/SAP DEVIATIONS

The intent is to collect as complete a dataset as possible. Nevertheless, in some situations missing data cannot be avoided. The reports and tables therefore will show the number and percentage of missing cases for each analyzed variable in relation to the enrolled cases for each postoperative assessment.

Any deviations from the SAP will be listed in the annual or final reports.

11.5. REPORTS

11.5.1. Interim Analysis and Reports

Interim analyses will be performed on a yearly basis. The progress of the clinical investigation will be reported together with the interim results on the variable level according to the analysis plan.

The analysis of the primary endpoint will be part of the related interim/annual report when all subjects have completed the 24 months postoperative including the ASES Shoulder Score.

11.5.2. Final Analysis and Reports

The full final report with complete analysis including progress and conduct reporting will be created at the end of this clinical investigation.

12. Clinical Investigation Plan Deviations

A CIP deviation is a departure from the approved CIP that is not implemented or intended as a systemic change. All CIP deviations are recorded and reported to each site's IRB in accordance with the respective site's IRB policies.

13. Adverse Events

As this CIP is being carried out to satisfy the post-market requirements to support safety and efficacy/performance according to the European Medical Device Regulation (EU MDR), categorization and definition of device-related AEs will follow the guidelines outlined in the EU MDR as "incident" reporting.

13.1. DEFINITIONS

- **An Adverse Device Effect (ADE)** is defined as any untoward or unintended response to the clinical investigation treatment; and/or a medical response which may have a causal relationship to the treatment.
- **An Incident** is defined as any malfunction or deterioration in the characteristics or performance of a device made available on the market, including use-error due to ergonomic features, as well as any inadequacy in the information supplied by the manufacturer and any undesirable side-effect.
- **A Serious Adverse Device Effect (SADE)** is defined as any ADE that results in consequences characteristic of a SAE or might lead to the consequences if suitable action or intervention is not taken; causes considerable interference with the subject's usual activities and may be incapacitating or life-threatening, including those events resulting in a subject's disability or permanent damage, or required intervention to prevent disability or permanent damage; results in a life-threatening illness or injury; and/or results in death (fatal).
- **A Serious Incident** is defined as any incident that directly or indirectly led, might have led or might lead to any of the following:
    - the death of a patient, user or other person;
    - the temporary or permanent serious deterioration of a patient's, user's or other person's state of health;
    - a serious public health threat
- **An Unanticipated Adverse Device Effect (UADE)** is defined as an AE not described in the informed consent, CIP or device labeling which has resulted in any of the consequences of a SAE or which might have led to any of the consequences of a SAE if suitable action had not been taken, intervention had not occurred, or if circumstances had been less opportune.

13.2. ADVERSE EVENT SEVERITY

The severity of all AEs is assessed by the Investigator utilizing the following categories:

- **Mild:** The AE is transient and easily tolerated by the subject.
- **Moderate:** The AE causes the subject discomfort and interrupts the subject's usual activities.
- **Severe:** The AE causes considerable interference with the subject's usual activities and may be incapacitating or life-threatening, including those events resulting in a subject's disability or permanent damage, and/or required intervention to prevent permanent disability or damage.
- **Life-Threatening:** The AE results in a life-threatening illness or injury.
- **Fatal:** The AE results in death.

13.3. RELATIONSHIP TO THE DEVICE

Only events considered possibly, probably or definitely related to the device will be captured for this clinical investigation.

13.4. ADVERSE EVENT/INCIDENT REPORTING

In the event a SADE, UADE or serious incident occurs, the Investigator is required to notify the Sponsor within 48 hours of being made aware of the event. The Investigator also is required to notify their IRB in accordance with the policies of their local laws and regulations.

13.5. FORESEEABLE ADEs, SADEs and INCIDENTS

ADEs, SADEs and incidents which may be expected as part of the surgical intervention include:

- *Perioperative complications*
  - Malpositioning of the humeral or glenoidal component
  - Oversizing of implant components
  - Undersizing of implant components
  - Intraoperative fracture of the humerus or glenoid
  - Cement leakage, if applicable
  - Insufficient reduction of the greater or lesser tuberosities
  - Nerve injury, mild (minor motor or sensory loss, or spontaneous recovery)
  - Nerve injury, severe (significant motor or sensory loss or requiring surgical revision)
  - Vessel injury
  - Tendon injury
  - Wound complications (e.g. hematoma, wound healing disturbances)
  - Superficial infection
  - Deep infection
  - Deep vein thrombosis
  - Pulmonary embolism

- *Complications in the follow-up period*
  - Implant dislocation
  - Other subluxation or instability, symptomatic
  - Implant component dissociation, humeral cup from humeral stem
  - Implant component dissociation, humeral head from humeral stem
  - Implant component dissociation, humeral insert from humeral cup
  - Implant component dissociation, glenosphere from baseplate
  - Implant fretting or crevice corrosion
  - Implant breakage/wear, humeral or glenoidal
  - Implant loosening, humeral or glenoidal
  - Implant loosening, humeral or glenoidal with or without screw breakage
  - Radiographic lucency, humeral or glenoidal
  - Rotator cuff tear
  - Pain related to the implant, severe
  - Late infection (e.g. hematogenous or protracted)
  - Periprosthetic fracture of the humerus or glenoid
  - Secondary displacement of the greater or lesser tuberosities
  - Stiffness
  - Stress fracture of the acromion or the scapular neck
  - Stress fracture of the coracoid
  - Scapular notching, asymptomatic or symptomatic

- Suture granuloma
- Heterotopic ossification, asymptomatic or symptomatic
- Healing disturbances of subscapularis tenotomy, if applicable
- Non-union of lesser tuberosity osteotomy, if applicable
- Non-union of primary fracture
- Malunion of lesser tuberosity osteotomy, if applicable
- Malunion of primary fracture
- Wound complications (e.g. hematoma, wound healing disturbances)
- Superficial infection
- Deep infection
- Deep vein thrombosis
- Pulmonary embolism

14. Revisions, Removals and Reoperations

Reoperations and reason(s) for reoperations will be collected throughout the course of the clinical investigation. A reoperation may include but not limited to irrigation and debridement, revision surgery and/or implant removal.

15. Ethics

This clinical investigation is to be conducted according to International Conference of Harmonisation of Good Clinical Practice (ICH-GCP), applicable regulations, institutional research policies and procedures, Declaration of Helsinki and in compliance with the CIP. Investigators will be trained on the clinical investigation devices and surgical techniques prior to implanting clinical investigation subjects.

This CIP and any amendments will be submitted to a properly constituted independent ethics board, in agreement with local legal prescriptions, for formal approval of the clinical investigation conduct. The decision of the ethics board concerning the conduct of the clinical investigation will be made in writing to the Site Principal Investigator before commencement of this clinical investigation. Clinical investigations shall not begin until the governing regulatory authority has provided full, unconditional approval. Off-label use of the ReUnion RFX System is not permitted.

15.1. INSTITUTIONAL REVIEW BOARD (IRB)

IRB approval will be obtained at each of the investigational sites prior to enrolling clinical investigation subjects at that site. In addition, any SAEs and UADEs that meet the reporting criteria of the IRB, will be reported to the IRB. During the clinical investigation, the Investigator should promptly provide written reports to the IRB of any changes that affect the conduct of the clinical investigation and/or increase risk to the subjects, unless otherwise submitted by the Sponsor.

15.2. INFORMED CONSENT

The Investigator, or qualified clinical investigation personnel designated to perform this task, will explain the nature of the clinical investigation to the subject, and answer all questions regarding participation in this clinical investigation. Prior to any clinical investigation procedures being performed, the informed consent form (ICF) will be reviewed, signed and dated by the subject, and by the person administering the informed consent. A copy of the ICF will be given to the subject, and the original will be placed in the subject's clinical investigation records. Subjects will need to sign updated versions of the ICF if required by the Investigator's IRB during the clinical investigation.

16. Data Collection Process

The Sponsor will collect clinical data for this clinical investigation utilizing eCRFs through an EDC system. All data entered in the eCRFs are supported by source documentation. All clinical data is entered into the EDC system by designated personnel at each of the Investigator sites.

16.1. RADIOGRAPHS

All radiographs shall be de-identified of personal health information. Radiographs will be uploaded as DICOM images into the EDC system. The radiologic analysis shall be based at minimum on an axillary lateral radiograph and an anteroposterior radiograph. Additional radiographs (e.g., 30° to 40° posterior oblique radiographs in internal and external rotation) may be used where available. For measurements, all digital radiographs shall be sized to 100%, based on the diameter of the humeral head, glenosphere or other suitable reference sizes.

17. Clinical Investigation Monitoring

It is the responsibility of the Investigator to oversee the safety of the clinical investigation at his/her site, to include the careful assessment and appropriate reporting of AEs as noted above as well as the implementation of site data safety. The Sponsor, or designee will monitor the site to ensure informed consent has been documented appropriately, to ensure the information documented on the completed CRFs match the medical records and to resolve any differences. The Sponsor will take all steps necessary to ensure data integrity. The Sponsor also will review significant new information, including UADEs and ensure that such information is provided to all Investigators, their IRBs, and applicable regulatory authorities. Additionally, a quality assurance check will be performed to ensure the investigator is complying with the CIP and applicable regulations in the collection of all clinical investigation data.

18. Data Handling and Record Keeping

Information about clinical investigation subjects will be kept confidential. In the event a subject revokes authorization to collect or use protected health information, the Site Investigator, by regulation, retains the ability to use all information collected prior to the revocation of subject authorization. The Health Insurance Portability and accountability Act (HIPAA) will apply to ensure data protection and document anonymization. Records are to be stored in a secure location. Retention of records shall be maintained through the clinical investigation duration as well as specified years following the clinical investigation completion as required by local regulatory authority.

19. Reports

Analysis will be performed and interim reports will be prepared on a yearly basis. Upon the completion of all subjects' final postoperative assessment, data freeze will occur, and the final report will be prepared.

20. Completion of the Clinical Investigation

The Investigator will conduct this clinical investigation in compliance with the CIP and will complete the clinical investigation within the timeframe specified in the contract. Continuation of the clinical investigation beyond this time must be mutually agreed upon in writing by both the Investigator and Stryker. The Investigator will provide a summary of the clinical investigation results in accordance with the IRB/EC guidelines.

Stryker may terminate this clinical investigation prematurely, either in its entirety or at this site, for reasonable cause provided that written notice is submitted a reasonable time in advance of the intended termination. The Investigator may also terminate the clinical investigation at their site for reasonable cause, after providing written notice to Stryker a reasonable time in advance of the intended termination. If Stryker terminates the clinical investigation for safety reasons, it will immediately notify the Investigator by telephone and subsequently provide written instructions for clinical investigation termination.

21. Essential Documents

All essential documentation will be stored as specified under the Sponsor's Standard Operating Procedures.

22. Publication Policy

Refer to the clinical investigation agreement for the publication policy.

23. References

1. Shulka DR, McAnany S, Kim J, Overley S, Parsons BO. Hemiarthroplasty versus reverse shoulder arthroplasty for treatment of proximal humeral fractures: a meta-analysis. J Shoulder Elbow Surg. 2016;25: 330-340.

2. Cuff DJ, Pupello DR, Santoni BG, Clark RE, Frankle MA. Reverse Shoulder Arthroplasty for the Treatment of Rotator Cuff Deficiency: A Concise Follow-up, at a Minimum of 10 Years, of Previous Reports. J Bone Joint Surg Am. 2017 Nov 15; 99(22):1895-1899.

3. Sebastiá-Forcada E, Cebrián-Gómez R, Lizaur-Utrilla A, Gil-Guillén V. Reverse shoulder arthroplasty versus hemiarthroplasty for acute proximal humeral fractures. A blinded, randomized, controlled, prospective study. J Shoulder Elbow Surg. 2014 Oct;23(10):1419-26.

4. Baudi P, Campochiaro G, Serafini F, Gazzotti G, Matino G, Rovesta C, Catani F. Hemiarthroplasty versus reverse shoulder arthroplasty: comparative study of functional and radiological outcomes in the treatment of acute proximal humerus fracture. Musculoskelet Surg. 2014 Apr;98 Suppl 1:19-25.

5. Chalmers PN, Slikker W 3rd, Mall NA, Gupta AK, Rahman Z, Enriquez D, Nicholson GP. Reverse total shoulder arthroplasty for acute proximal humeral fracture: comparison to open reduction-internal fixation and hemiarthroplasty. J Shoulder Elbow Surg. 2014 Feb;23(2):197-204.

6. Cuff DJ, Pupello DR. Comparison of hemiarthroplasty and reverse shoulder arthroplasty for the treatment of proximal humeral fractures in elderly patients. J Bone Joint Surg Am. 2013 Nov 20;95(22):2050-5.

7. Garrigues GE, Johnston PS, Pepe MD, Tucker BS, Ramsey ML, Austin LS. Hemiarthroplasty versus reverse total shoulder arthroplasty for acute proximal humerus fractures in elderly patients. Orthopedics. 2012 May;35(5): e703-8.

8. Young SW, Segal BS, Turner PC, Poon PC. Comparison of functional outcomes of reverse shoulder arthroplasty versus hemiarthroplasty in the primary treatment of acute proximal humeral fracture. ANZ J Surg. 2010 Nov;80(11):789-93.

9. Gallinet D, Clappaz P, Garbuio P, Tropet Y, Obert L. Three or four parts complex proximal humerus fractures: hemiarthroplasty versus reverse prosthesis: a comparative study of 40 cases. Orthop Traumatol Surg Res. 2009 Feb;95(1):48-55.

24. Clinical Investigation Plan Signature Page

ReUnion RFX System

I have read this Clinical Investigation Plan and agree that this clinical investigation is ethical. I agree to conduct this clinical investigation in accordance with this Clinical Investigation Plan, as well as all applicable regulations and guidelines. I agree to maintain the confidentiality of all information received or developed in connection with this Clinical Investigation Plan.

Signature of Investigator	Date of Signature
Name of Investigator (Printed)	

25. Document Version History

Version	Effective Date	Description	Revised/Created by
1	10Jan2019	Initial version	Lindsay Mattfolk
2	08Aug2019	See tracked version for description of changes.	Emily Arndt