PROFOUND MEDICAL

Incision & Radiation-Free Surgery
Real-Time MR Guided Ultrasound Therapies

CORPORATE PRESENTATION | October 2018

 TSX: PRN | OTCQX: PRFMF

Forward-Looking Statements

Certain statements in this presentation and oral statements made during this meeting may contain “forward-looking statements” within the meaning of applicable securities laws, including the “safe harbour provisions” of the Securities Act (Ontario), with respect to Profound Medical Corporation (“Profound” or the “Company”). Such statements include all statements other than statements of historical fact contained in this presentation, such as statements that relate to the Company’s current expectations and views of future events. Often, but not always, forward-looking statements can be identified by the use of words such as “may”, “will”, “expect”, “anticipate”, “predict”, “aim”, “estimate”, “intend”, “plan”, “seek”, “believe”, “potential”, “continue”, “is/are likely to”, “is/are projected to” or the negative of these terms, or other similar expressions, as well as future or conditional verbs such as “will”, “should”, “would”, and “could” intended to identify forward-looking statements. These forward-looking statements include, among other things, statements relating to expectations regarding future clinical trials, expectations regarding regulatory approvals, expectations regarding the safety and efficacy of its product, expectations regarding the use of its product and its revenue, expenses and operations, plans for and timing of expansion of its product and service offerings, future growth plans, ability to attract and develop and maintain relationships with suppliers, manufacturers, physicians/clinicians, etc., ability to attract and retain personnel, expectations regarding growth in its product markets, competitive position and its expectations regarding competition, ability to raise debt and equity capital to fund future product development, and anticipated trends and challenges in Profound’s business and the markets in which it operates.

Forward-looking statements involve known and unknown risks, uncertainties and other factors which may cause the actual results, performance or achievements of the Company to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements. The results, performance and achievements of the Company will be affected by, among other things, the risks and uncertainties discussed in the “Risk Factors” section in the Company’s Annual Information Form dated April 20, 2018, such as successful completion of clinical trial phases with respect to Profound’s device, obtaining regulatory approvals in relevant jurisdictions to market Profound’s device, risks related to the regulation of Profound (including the healthcare markets, lack of funding may limit the ability to commercialize and market Profound’s products, fluctuating input prices, international trade and political uncertainty, healthcare regulatory regime in relevant jurisdictions may affect the Company’s financial viability, reimbursement models in relevant jurisdictions may not be advantageous), competition may limit the growth of Profound, if the Company breaches any of the agreements under which it licenses rights from third parties, Profound could lose license rights that are key to its business, loss of key personnel may significantly harm Profound’s business and past performance is not indicative of future performance, and such other risks detailed from time to time in the other publicly filed disclosure documents of the Company which are available at www.sedar.com. The Company’s forward-looking statements are made only as of the date of this presentation and, except as required by applicable law, Profound disclaims any obligation to update any forward-looking statements, whether as a result of new information, future events or results or otherwise, unless required by applicable law. There can be no assurance that forward-looking statements will prove to be accurate, as actual results and future events could differ materially from those anticipated in such statements. Accordingly, and because of the above-noted risks, uncertainties and assumptions, readers should not place undue reliance on forward-looking statements due to the inherent uncertainty in them.

Technology Platform

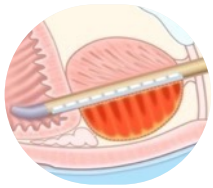
About Disease Treatment Not Organ Removal

Incision-free/Radiation-free Procedures

Real-Time MR guided

1. **Precise**
2. **Flexible**
3. **Safe**

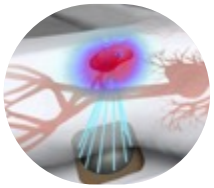
TULSA-PRO®



Treatment for prostate disease (cancer and BPH)

- CE marked
- FDA expected H2-2019

Sonalleve



Treatment for uterine fibroids, bone metastasis, pediatric

- CE marked
- China FDA approved for uterine fibroids

TULSA-PRO®

Prostate Ablation

- CE Mark
- FDA Registration Study Recruited

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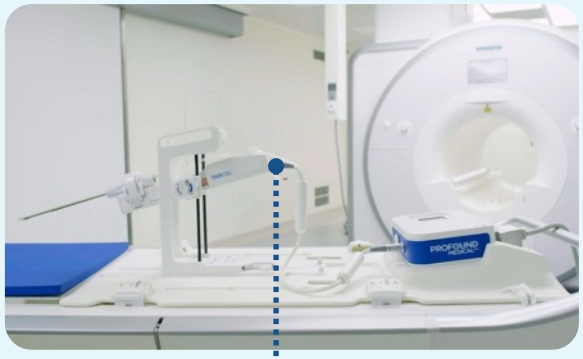
TULSA-PRO

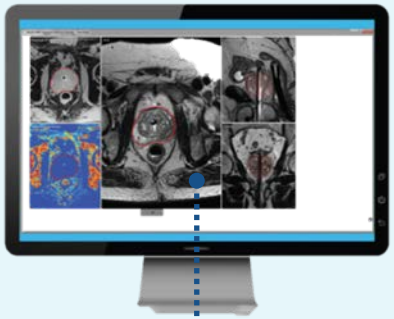
Equipment

Compatible with MR from leading companies – Philips and Siemens

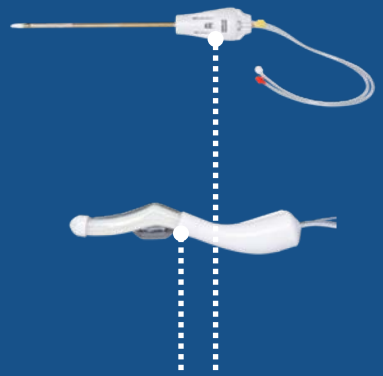


Robotic Arm,
Computer Hardware

Energy
System

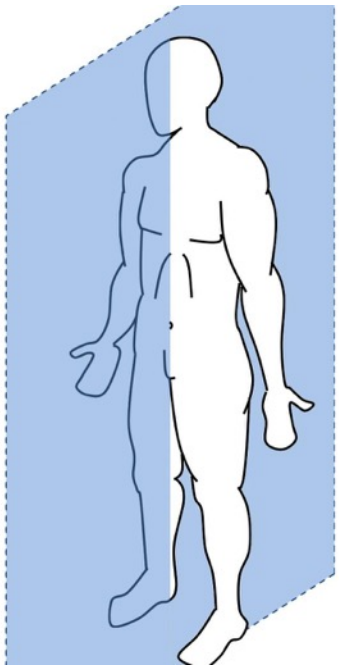


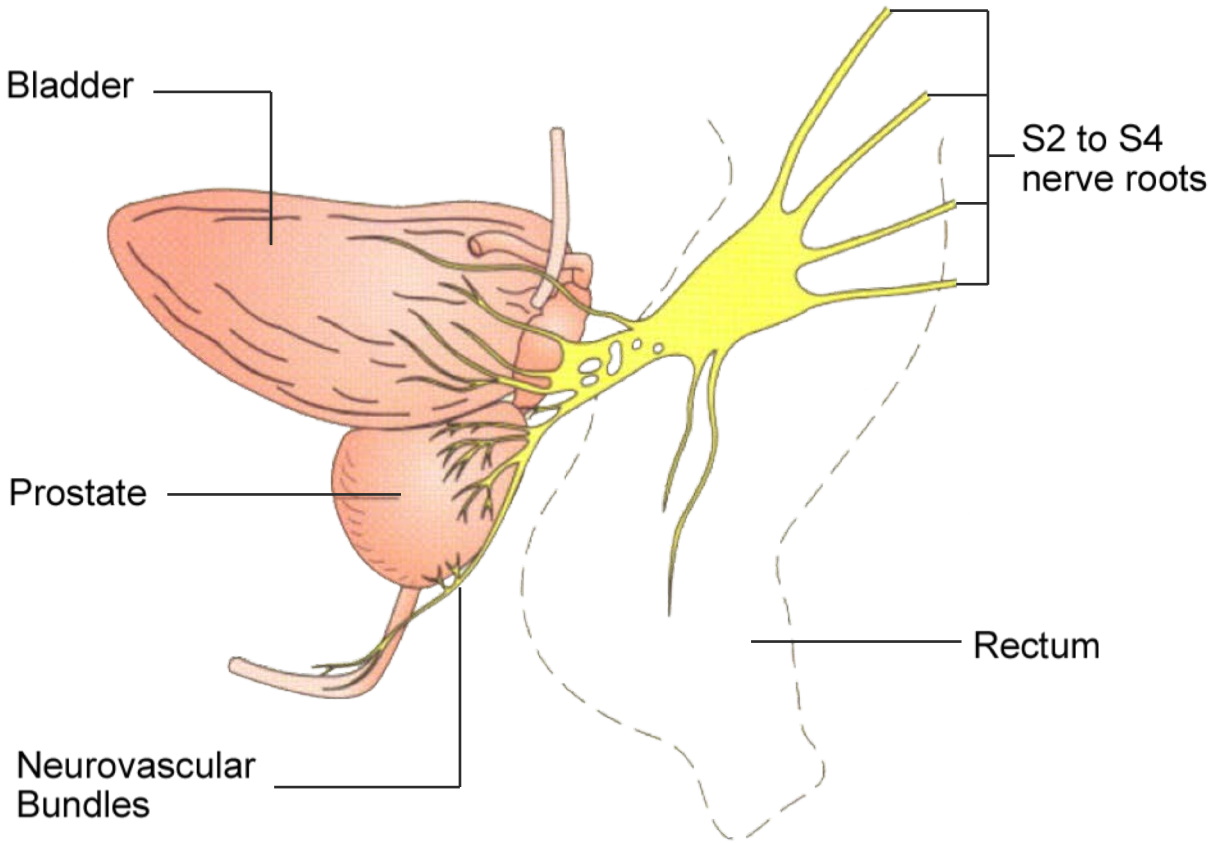
Surgeon Console
Control Room



Disposable
Applicators

The Prostate

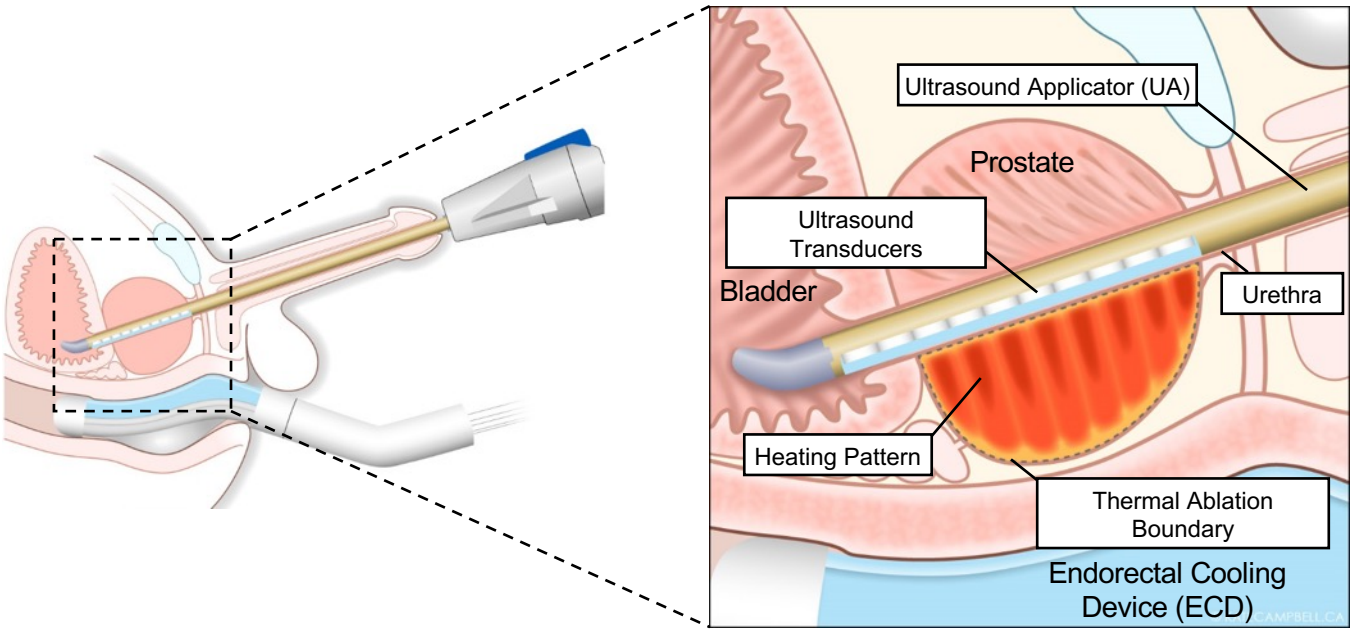




Kirby (1997) An Atlas of Prostatic Diseases, The Encyclopedia of Visual Medicine Series.

Protecting Critical Surrounding Anatomy

From Potential Side Effects



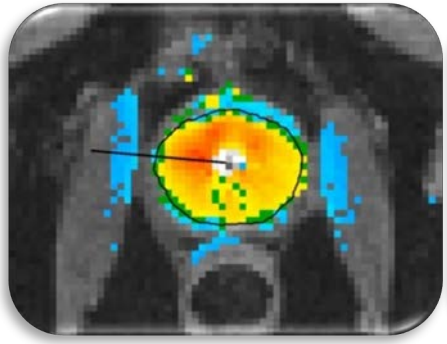
Safety by design

- Ablate from Inside-prostate; safer than outside-through rectum, able to treat prostates >140 cc
- Actively protects urethra and rectum via cooling
- MR and Ultrasound heating are safe modalities

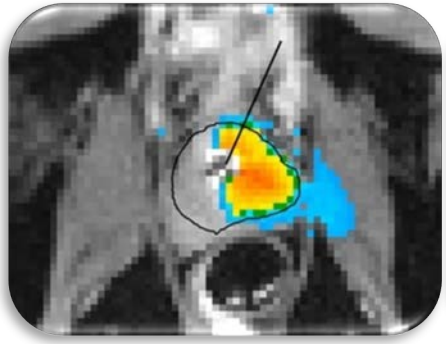
TULSA Flexibility

Precise Whole Gland or Customized Partial Gland Ablation

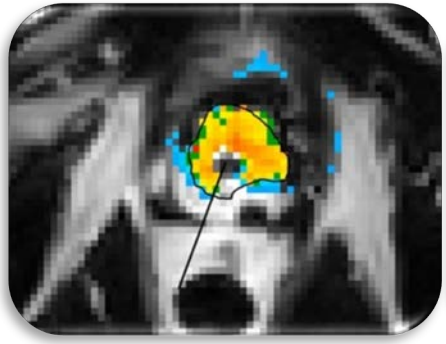
Whole Gland Ablation



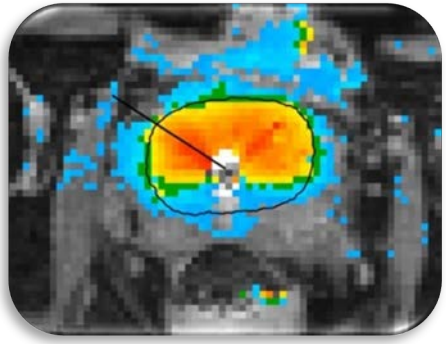
Targeted Ablation



Salvage Therapy Post Radiation Therapy Failure



Benign Prostate Hyperplasia (BPH)



Transurethral Ablation

Using Thermal Ultrasound with Real-time MR Guided Controlled Dosimetry

TULSA-PRO®

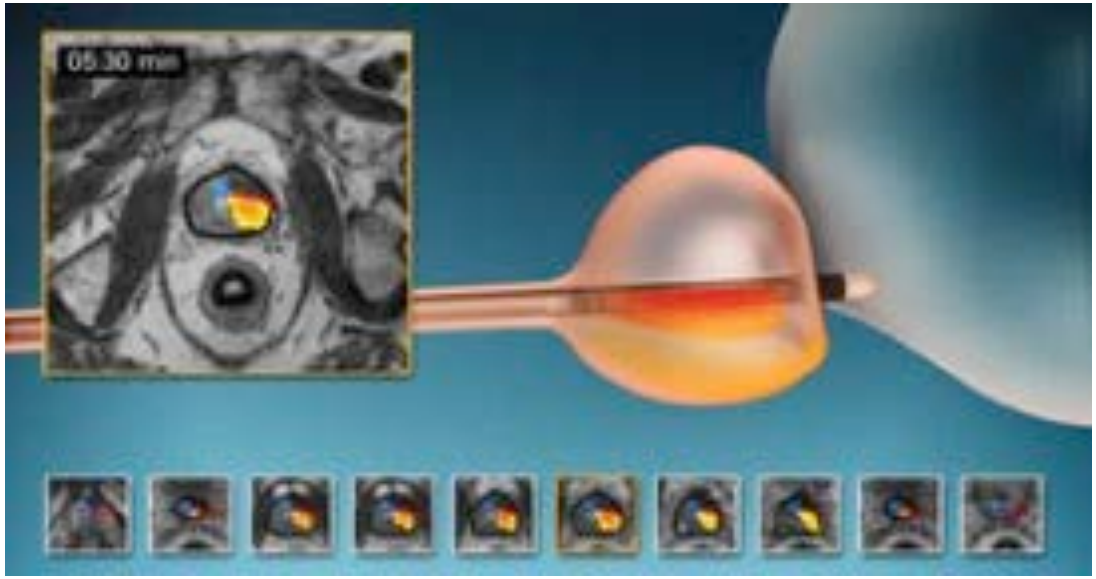
Precise ablation with millimeter accuracy

- Real-Time MR Imaging, thermometry, automated process control

Customized treatment to meet each patients particular need

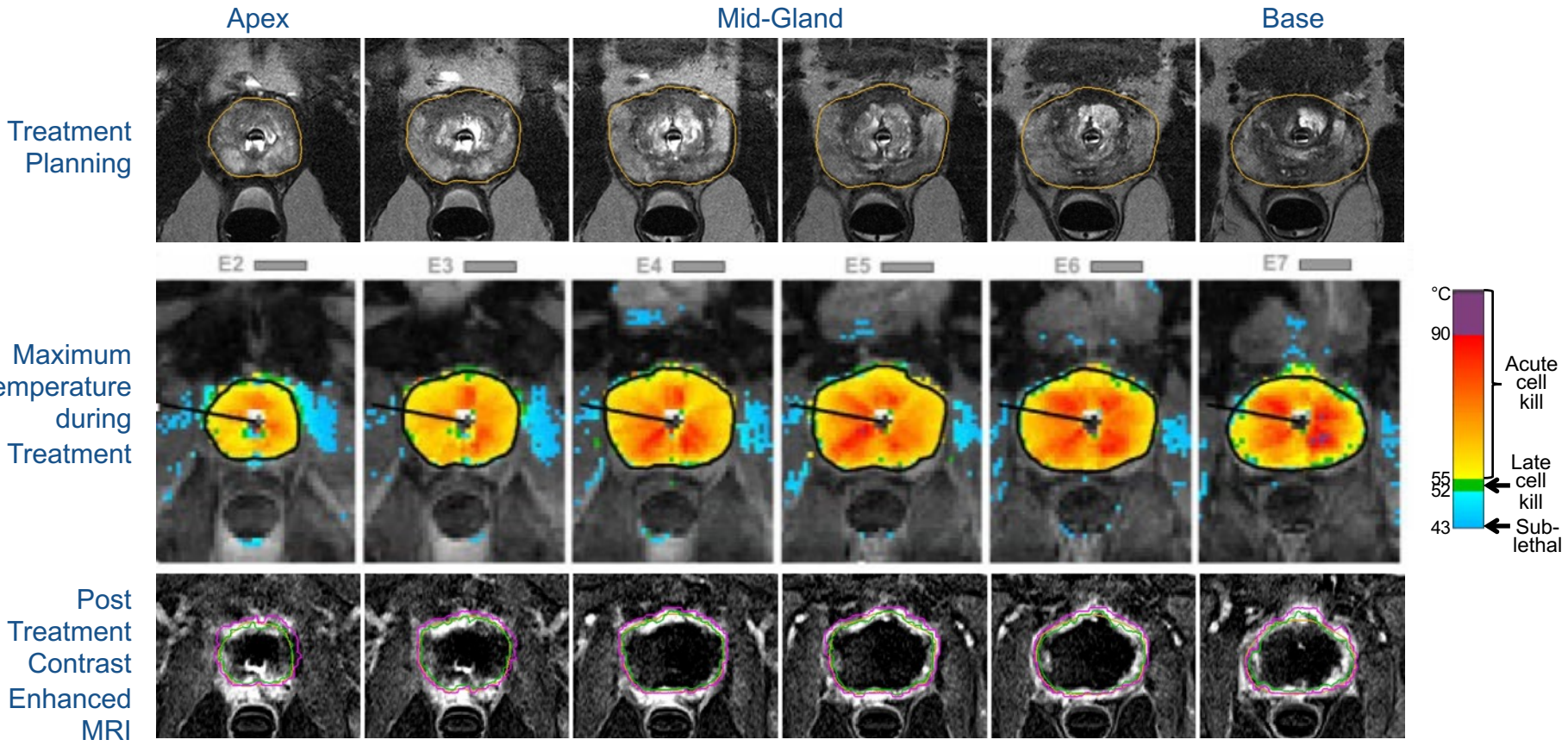
- Urologist defines region of ablation
- Full gland or targeted therapy for localized cancer
- BPH

Two hour procedure time



TULSA Procedure

Case Example (Axial Images)



Prostate Cancer Therapies Today

US + Europe

5.8 Million Patients living with PCa

Low Risk, PSA <10 ng/ml, GS 6 New diagnosed 200,000/year	Intermediate Risk, PSA 10-20, GS 7 New diagnosed 200,000/year	High Risk, PSA>20, GS>7 New 95,000/Yr

Active Surveillance

Surgery

Radiation Therapy

Unmet needs

1. Patients with active lives
2. Patients under active surveillance but don't want to wait, or also have BPH
3. Patients with co-morbidities preventing surgical intervention
4. Salvage patients who failed radiation treatment
5. Patients with early stage disease, Gleason Score (GS) = 3+3 but genetic testing indicates aggressive disease
6. Patients with mid stage disease with MRI visible disease pattern
7. BPH patients who value erectile and ejaculatory functions

Company Calculations based on PIVOT and CaPSURE registry data and following references (Wilt et al. The Prostate cancer Intervention Versus Observation Trial:VA/NCI/AHRQ Cooperative Studies Program #407 (PIVOT): design and baseline results of a randomized controlled trial comparing radical prostatectomy to watchful waiting for men with clinically localized prostate cancer. Contemp Clin Trials. 2009 Jan;30(1):81-7; Cooperberg M. et. Al. Time Trends and Local Variation in Primary Treatment of Localized Prostate Cancer. J Clin Oncol 28:1117-1123; American Cancer Society; International Agency for Research on Cancer. WHO. http://eco.iarc.fr/eucan/CancerOne.aspx?Cancer=29&Gender=1; seer.cancer.gov; European Alliance for Personalized Medicine, 2015

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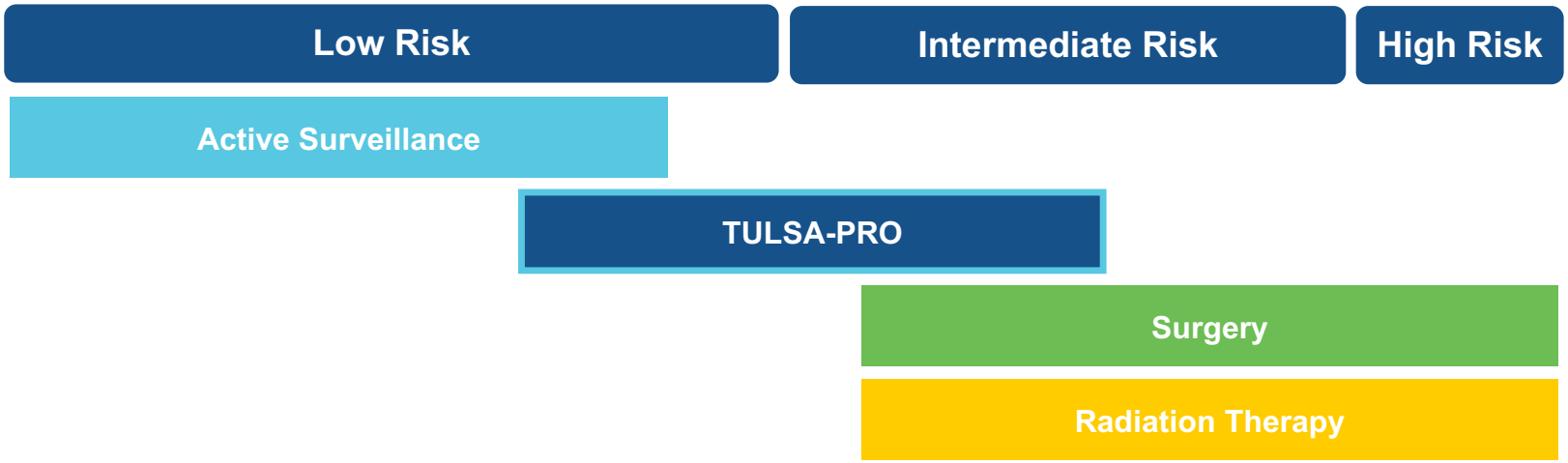
TULSA-PRO

Addressing Unmet Needs



Unmet needs

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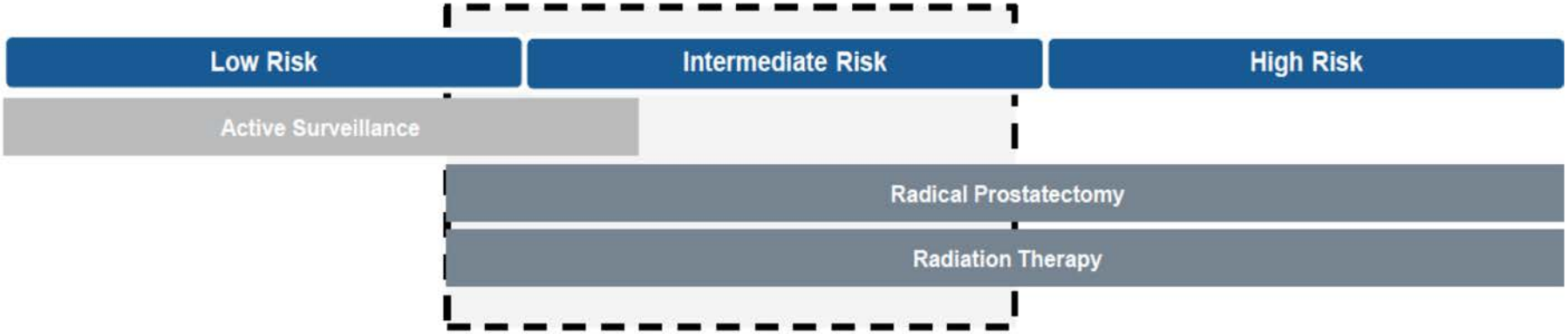
TULSA does not interfere with any additional intervention if needed in the future

No Standard of Care

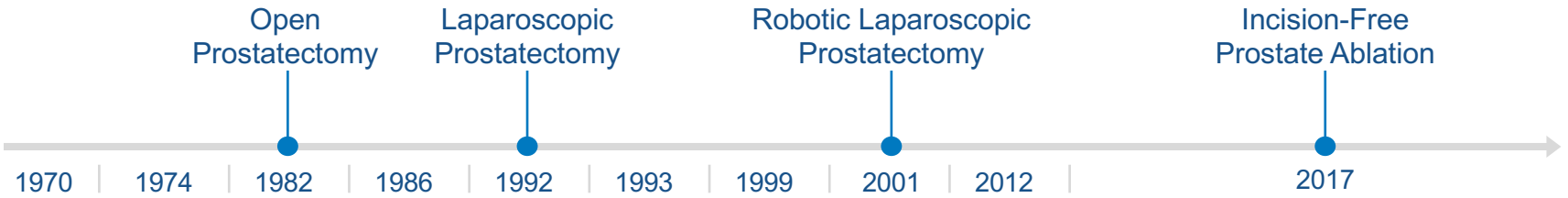
Relative Costs

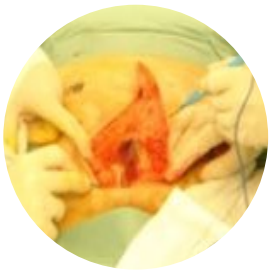


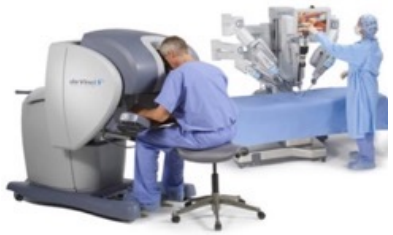
ACTIVE SURVEILLANCE	RADICAL PROSTATECTOMY	RADIATION THERAPY
Selected Delayed Treatment	Invasive Surgery	Ionizing Radiation (multiple fractions, 8 weeks)
• Serial monitoring: Biopsy, PSA, DRE, MRI • Psychological distress • Biopsies painful with 3% risk of sepsis	• Urinary incontinence (severe): 16% (4-31%) • Urinary stricture (req. Tx): 9% (3-26%) • Erectile dysfunction: 79% (25-100%)	• Bowel dysfunction: 25% (0-40%) • Urinary incontinence (severe): 4% (2-15%) • Erectile dysfunction: 63% (7-85%)
• >50% patients undergo prostatectomy or radiation within 5 years	• Success depends on surgeon skill • Inpatient & Weeks recovery time	• Risk of secondary cancers • Delayed response and assessment of treatment success (2 years) • 30% patients fail treatment
10 yr. cost: $29,000	Surgery cost: $15,692	Treatment cost: $27,564

Timeline

From Open Surgery to Incision & Radiation-Free Surgery







Whole gland removal, reduced hospital stay, faster patient recovery

Potential to Expand Urologist's Practice

- Potential to keep radiation candidates "in practice"
- Partnering, not competing with with radiology
- TULSA-PRO takes significantly less time to perform that proctectomy
- Frees up valuable surgery suite capacity

- Surgical planning with real time imaging
- Whole gland or disease targeted partial ablation of prostate

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TACT Pivotal Trial: Full Prostate Volume Ablation (99%)

To support FDA application, enrollment completion Feb 2018

Study population (2/3 Intermediate Risk)

- Low and intermediate risk PCa, 45-80 y, PSA ≤ 15, GS ≤ 3+4
- n = 115, 13 clinical sites, 5 countries

Treatment plan

- Reduced margins for complete ablation

Primary endpoints (12 months)

- Efficacy: PSA reduction ≥ 75%
- Safety: Frequency & severity of adverse events

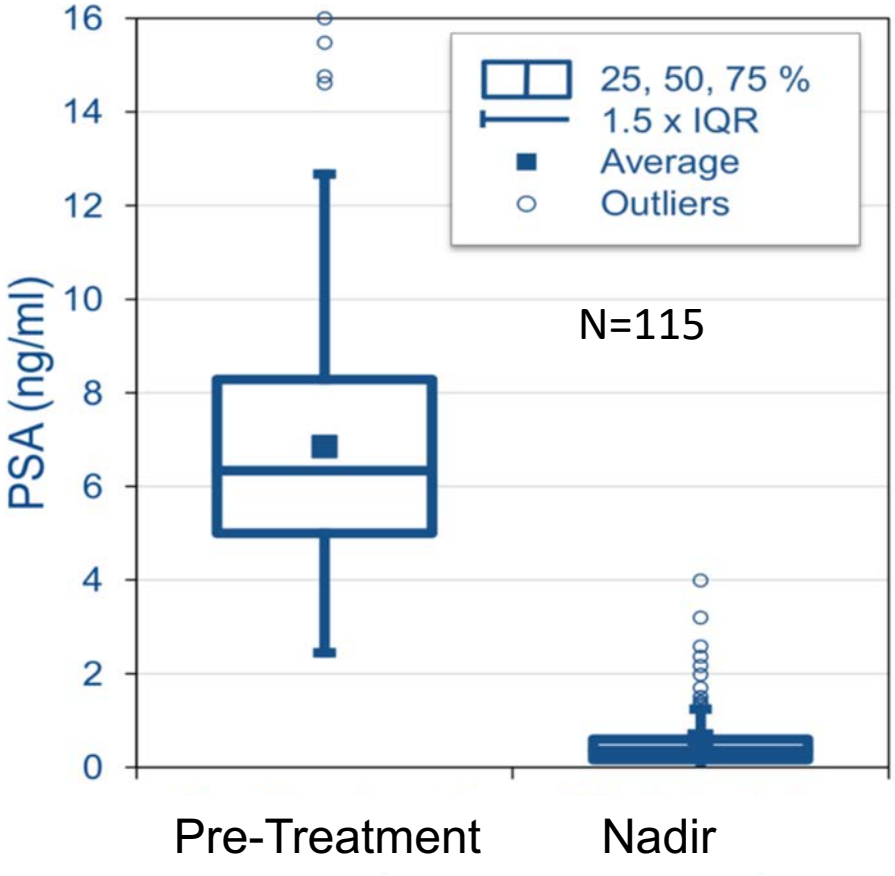
Secondary endpoints

- 12 month MRI and biopsy in all patients
- QoL: EPIC, IIEF, IPSS

TACT Pivotal Trial

Safety and PSA Outcomes

Full data expected in Spring 2019



Primary efficacy endpoint

- PSA nadir ≤ 25% of pre-tx baseline

Results to-date

- 95% of patients met PSA endpoint
- PSA reduction 95% (91 – 97%)
- PSA nadir 0.36 (0.16 – 0.60) ng/ml

Safety

- No rectal injury, No Grade ≥ 4 AE, No incontinence > Grade 1
- Attributable Serious AE in 7% of patients, all resolved: 3 G2 retention, 3 GS infection, 1 urinoma, 1 ileus, 1 DVT

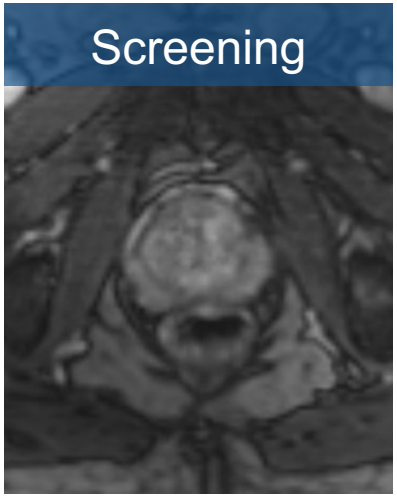
Case Study

TACT Trial Patient

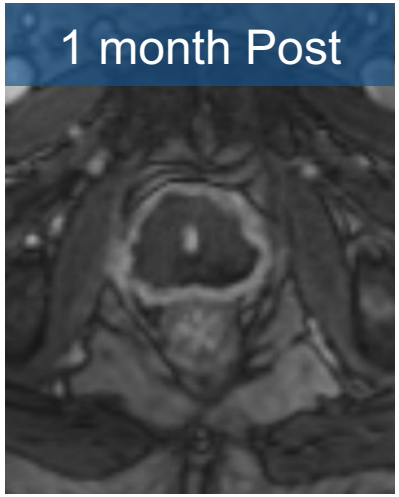
67 year old

Gleason 3+4 (L mid, R apex, R anterior)

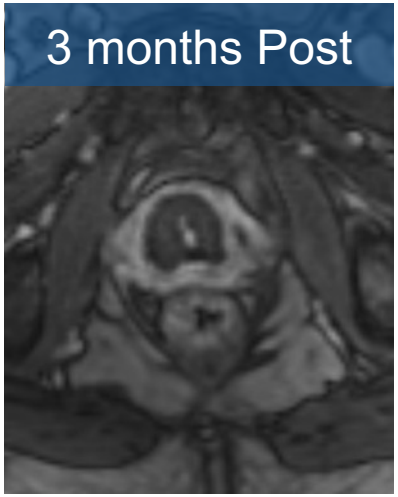
MRI-visible L mid anterior 14mm



PSA 6.0 ng/ml



PSA 0.28 ng/ml



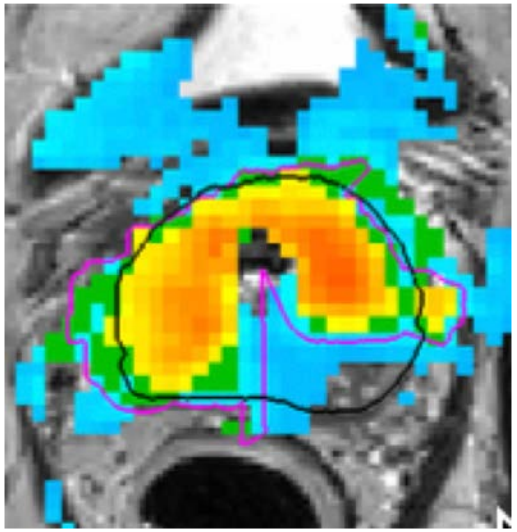
PSA 0.09 ng/ml

BPH Tissue Ablation

TULSA-PRO Addressing Unmet Need

Unmet needs (20% of men over 50, 60% of men over 60 have BPH)

1. Patients with stage IV disease: >80cc prostate
2. Patients with both cancerous and BPH tissue

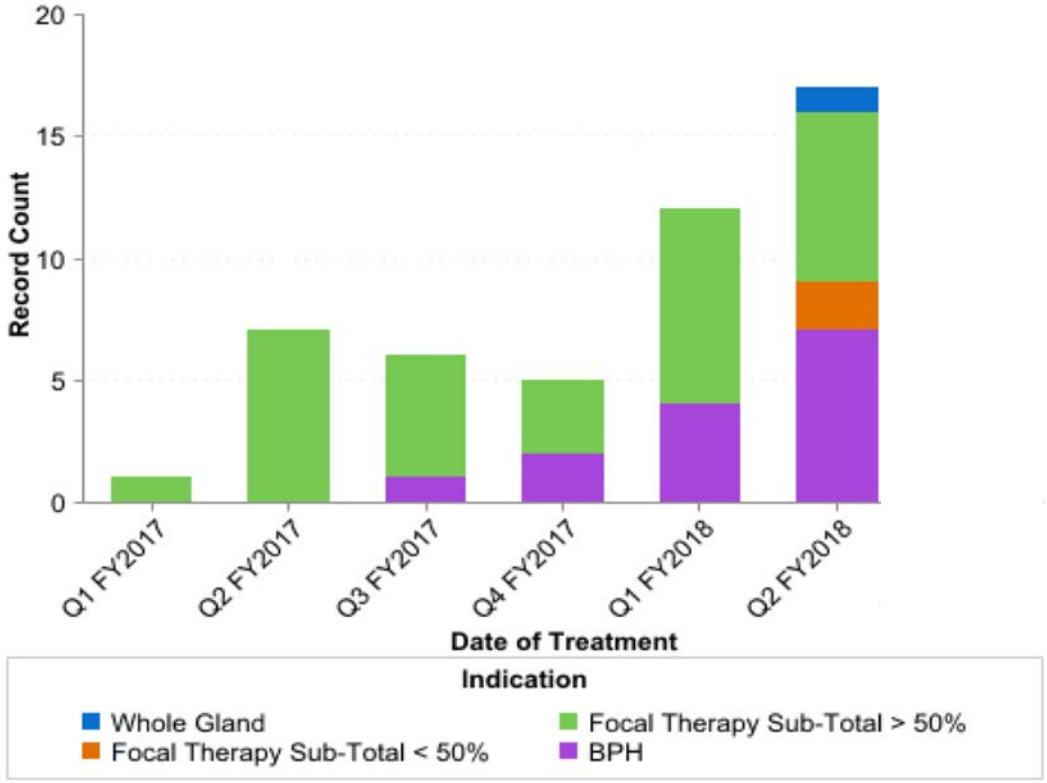


Patient with BPH and early stage lesion

Expanded Use: Prostate Cancer ➤ BPH

Pilot Launch In Europe: Case Study

- Initiated use of TULSA-PRO for targeted/focal therapy – Q1-2017
- Monitored treated patients methodically for six months
- Increased usage to BPH patients – Q3-2017
- Further added full gland higher grade cancer patients, and <50% focal ablation – Q2-2018
- Routine – 3 cases /day

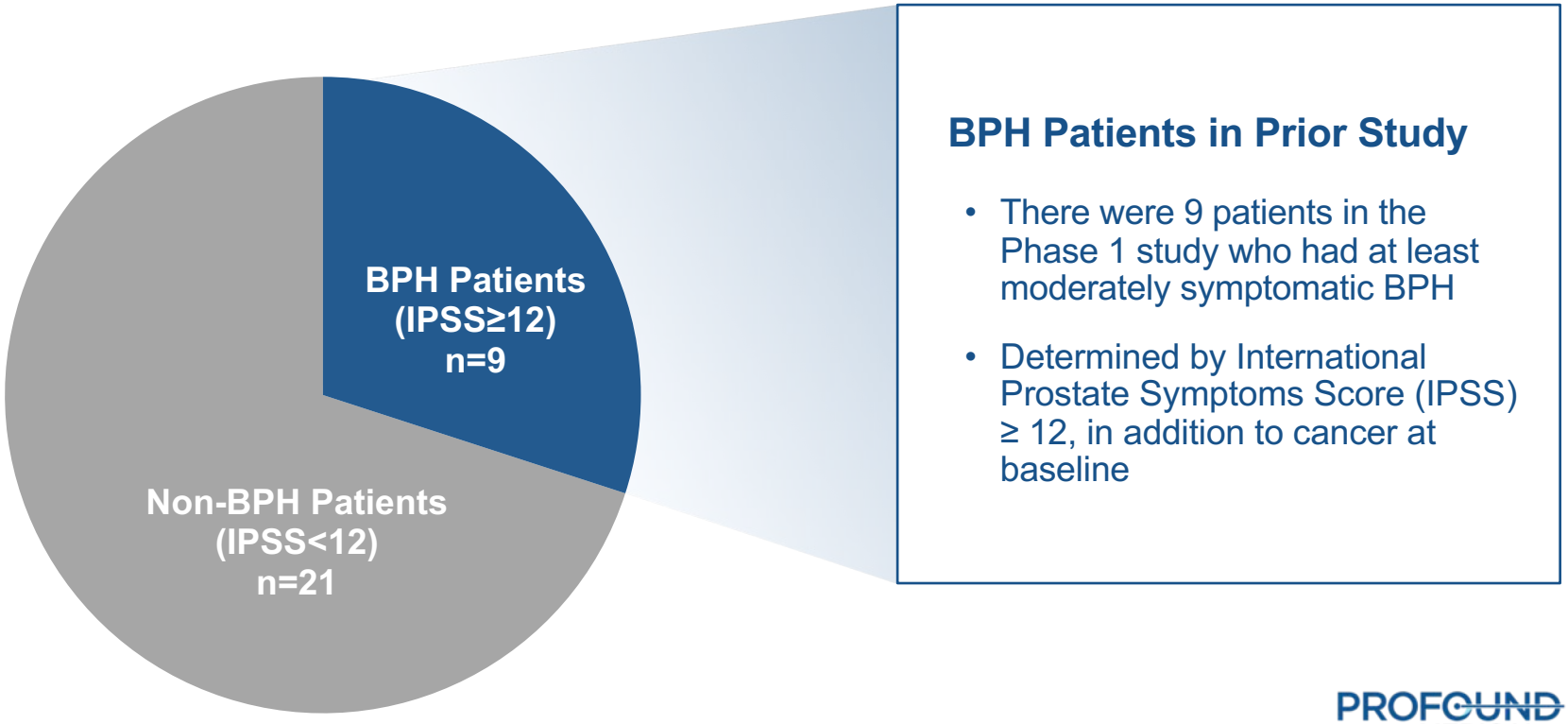


Retrospective Analysis

of TULSA-PRO in Patients with BPH

- Physicians involved in the TULSA trial observed strong anecdotal results in patients with BPH
- A retrospective examination of the quantitative results has shown a consistent trend

TULSA Phase 1 Study (n=30)



BPH Patients in Prior Study

- There were 9 patients in the Phase 1 study who had at least moderately symptomatic BPH
- Determined by International Prostate Symptoms Score (IPSS) ≥ 12, in addition to cancer at baseline

Feasibility

of TULSA-PRO for BPH

Retrospective subgroup analysis of 9/30 Phase I patients with IPSS ≥12 suggests similar urinary symptom relief as other surgical techniques

Characteristics	Baseline	12 months	Change (%)
IPSS	16.1 ± 3.8	6.3 ± 5.0	-9.8 ± 5.0 (58 ± 34%)
IPSS QoL	2.8 ± 1.1	0.8 ± 1.0	-2.0 ± 1.7 (66 ± 48%)
Prostate Volume (cc)	54 ± 23	14 ± 5	-40 ± 24 (70 ± 19%)
Peak flow (Qmax, ml/s)	14.5 ± 4.1	21.9 ± 12.7	+7.4 ± 13 (60 ± 93%)

No Grade 3 adverse events, erectile function (IIEF) stable from 15±9 to 16±9,
% Patients with erections sufficient for penetration (IIEF Q2 ≥2): from 7/9 to 8/9 men

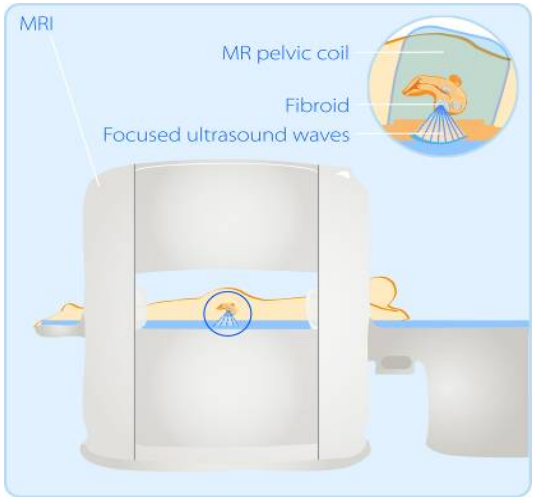
SONALLEVE

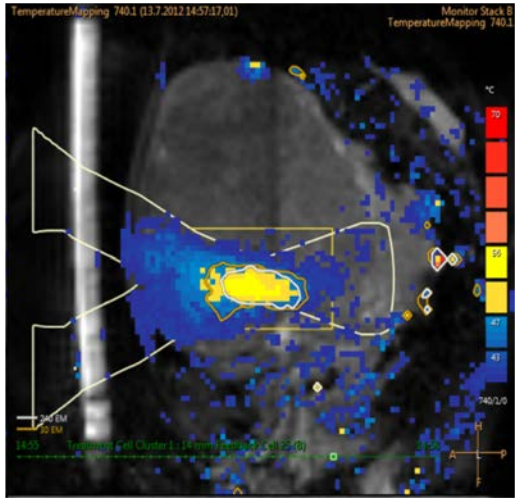
Technology platform for:

- Uterine Fibroid Treatment
- Bone Metastasis Pain
- Pediatric bone
- Hyperthermia

Over 200 publications from leading US and European clinicians and hospitals

CE Marked
CFDA Approved





Uterine Fibroid

Symptom Relief & Durability

In normal commercial use, over 85% of patients experienced sustained symptom improvement

Months post-procedure	Patients available for follow-up	Symptom improvement		
		Improved	No relief	Worse
3 months	105	90 (85.7%)	14 (13.3%)	1 (1%)
6 months	99	92 (92.9%)	7 (7.1%)	0
12 months	89	78 (87.6%)	11 (12.4%)	0

Durability of the therapeutic effect compared to other uterine preserving treatments

Need for alternative treatment	@ 12 month	@ 24 month	References
Myomectomy	10.6 %	13-16.5 %	1,2,3,4
UAE (Uterine Artery Embolization)	7-10 %	12.7-23.7 %	5,6,7
MR-HIFU/MRgFUSNPV >60%	6 %	13 %	8

"Volumetric MR-guided high-intensity focused ultrasound ablation of uterine fibroids: treatment speed and factors influencing speed," M. J. Park, Y. S. Kim, B. Keserci, H. Rhim, and H. K. Lim, Eur Radiol, vol. 23, no. 4, pp. 943–950, Apr. 2013. 1. Gorny KR, Woodrum DA et al. Magnetic resonance–guided focused ultrasound of uterine leiomyomas: review of a 12-month outcome of 130 clinical patients. J Vasc Interv Radiol 2011 2. Subramanian S, Clark MA, Isaacson K. Outcome and resource use associated with myomectomy. Obs & Gyn.2001; 98: 583-587 3. Nezhat FR, Roemisch M, et al. Recurrence rate after laparoscopic myomectomy. Am Assoc Gynecol Laparosc. 1998;5: 237-240 4. Rossseti et al. Long term results of laparoscopic myomectomy: recurrence rate in comparison with abdominal myomectomy. Hum Reprod. 2001:16:770-774 5. Doridot et al. Recurrence of leiomyomata after laparoscopic myomectomy. J Am Assoc Gynecol Laparosc. 2001;8: 495-500 6. Spies JB, Bruno J, et al. Long-term outcome of uterine artery embolization of leiomyomata. Obstet Gynecol. 2005; 106: 933-939 7. Goodwin SC, Spies JB, et al. Uterine artery embolization for treatment of leiomyomata: long-term outcomes from FIBROID registry. Obstet & Gynecol. 2008; 111: 22-32 8. Sharp HT. Assessment of new technology in the treatment of idiopathic menorrhagia and uterine leiomyomata. Obstet Gynecol. 2006;108: 990–1003

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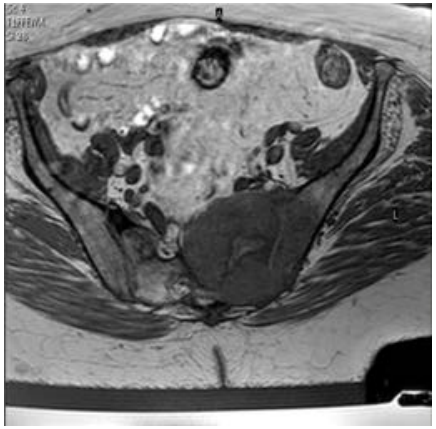
Sonalleve: Bone Metastasis Pain Therapy

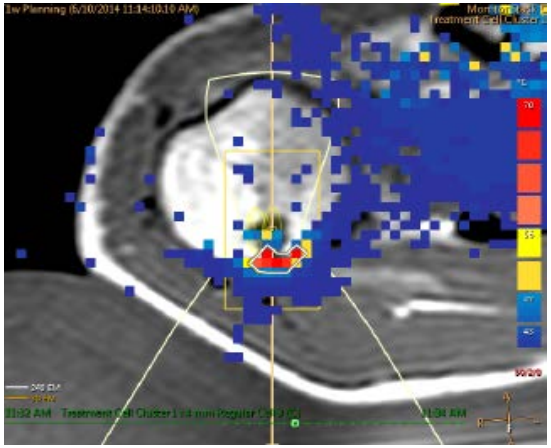
Non-invasive alternative to radiotherapy

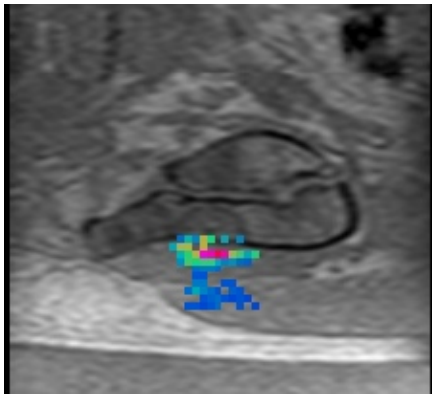
Most patients with slow growing tumors develop bone metastasis in the later stage of the disease.

Bone changes and malformations irritate nerve endings creating significant pain for patients.

- Radiotherapy standard of care for bone mets, but 20-30% of patients do not respond
- Sonalleve as non-invasive alternative to radiotherapy
- Heating of bone surface, ablation of periosteal nerves
- Quick pain relieve in 2-3 days, vs. radiotherapy typical 3 weeks

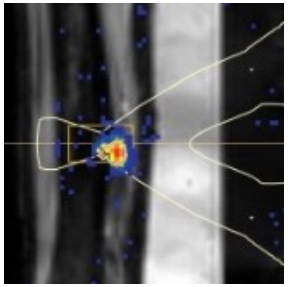






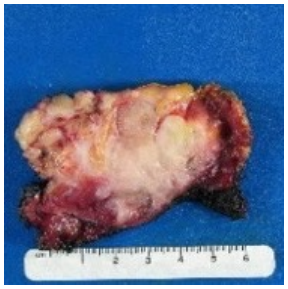
Exploring Further Indications on Current Platform

Pediatrics, Hyperthermia



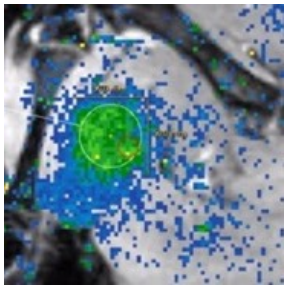
Pediatrics: Osteoid osteoma

- Very painful, benign bone tumor in children and young adults
- MR-HIFU very effective, immediate pain relief and bone restructuring
- Standard of care is radiofrequency ablation (RFA, invasive)



Pediatrics: Desmoid tumors (Fibromatosis)

- Benign aggressively growing tumors, everywhere in the body
- Can cause severe (bulk) symptoms
- Surgery (+/- radiotherapy) is standard of care, but high risk of recurrence
- Successful MR-HIFU treatments presented as individual case studies



Hyperthermia

- Increase tumor sensitivity to Radiation and Chemo Therapy
- Local heating to 40 – 43°C, precise control of temperature and lesion size
- Adjuvant therapy to chemotherapy or radiation therapy
- Enabling technology for Local Drug Delivery

Adoption Strategy

Profound Platform

TULSA-PRO

1. Pilot launch in Europe
   - Further clinical data generation
   - Confirmation of business model and value proposition
2. Complete TACT (pivotal study) clinical data set available in spring 2019
3. Full launch in US and Europe – H2, 2019
   - Submission to FDA for 510(k) – late spring 2019
   - Leverage existing agreements with Philips and Siemens for capital or new device installs
   - Build sales team to drive utilization as installed base grows

Sonalleve

1. Pilot launch in China
   - CFDA approved in May 2018
   - Leverage distribution agreement with Philips and its installed base of MR's in China
   - Initial focus – key opinion leading reference sites