

For all users of mint Lesion[™] version 3.10.0

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Urgent Field Safety Notice

For the Attention of: All users of mint Lesion™ version 3.10.0

Dear mint Lesion™ user.

We would like to inform you about a malfunction that may occur when using **mint Lesion™** in one of the versions listed below.

Information on affected devices

Affected medical device	mint Lesion™	
Basic UDI-DI	426049588MINTLESIONSM	

Affected mint Lesion™ device versions

Device Version	UDI-DI	UDI-PI
mint Lesion™ 3.10.0	04260495883106	(01)04260495883106(10)3.10.0(11)240911

Problem description

The malfunction is caused by a software error that is present in product version 3.10.0. The malfunction can occur in the following use scenario (all steps must apply):

- mint Lesion™ was already used in a version prior to 3.10.0
- 2. mint Lesion™ was upgraded to version 3.10.0
- 3. A user selects a patient record that was already present in the system before the upgrade to 3.10.0

Effects of the problem

mint Lesion™ always displays patient information about the currently selected patient in the upper left corner of each application screen. This allows the user to always discern the identity of the selected patient in order to avoid mistakenly assuming that a different patient is selected. When the malfunction occurs, the patient's name is not displayed. Instead, "--, --" is shown in place of the patient name (see Fig. 1, red rectangles). The patient ID and the date of birth of the patient are still shown correctly. This applies to the Manage screen, Read screen and Report screen only.



The patient list in the manage screen shows the name of the patient correctly (see Fig. 1, green rectangle). Exported reports (e.g., PDF, CSV, XML) contain the correct patient name. Patients imported with mint Lesion $^{\mathsf{TM}}$ 3.10 are not affected.

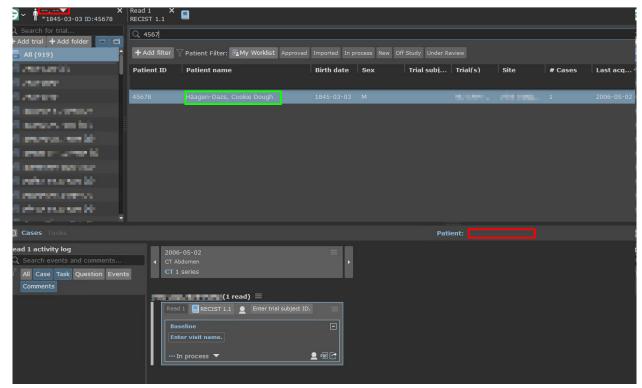


Figure 1: The patient name is not shown correctly

Actions to be taken by the user

Please read this information carefully and assess whether you are using an affected product version. If that is the case, the malfunction may occur in your system. Please be aware that the malfunction may occur.

If the problem occurs (Patient name not visible in top left corner of the application window), double-check that the correct patient record is opened to avoid attributing a radiological assessment to the wrong patient. You can identify which patient record is selected by

- switching to Manage screen and checking the selected entry in the patient list
- checking the displayed patient ID and date of birth
- creating a PDF report and checking the patient name in the PDF report

If you believe that this failure could have occurred in past use of mint Lesion $^{\text{\tiny{M}}}$, please review the potentially affected radiological reports that were manually transferred to your reporting application (as mint Lesion $^{\text{\tiny{M}}}$ -generated reports include the correct patient name) and take the necessary steps to correct them.

Actions being taken by the manufacturer

The error will be corrected by applying a configuration change to your mint Lesion™ installation. Mint Medical Support will apply this change to your system as soon as possible.



General Information

FSN Type	New Field Safety Notice	
Further advice or information already expected in follow-up FSN	Not planned	
Manufacturer information	Legal manufacturer name	Mint Medical GmbH
	Address	Mint Medical GmbH Burgstr. 61 69121 Heidelberg Germany
	Manufacturer Email	info@mint-medical.de
	Manufacturer Phone	+49 6221 64 79 76 0
	EUDAMED Single Registration Number (SRN)	DE-MF-000020202
	Person responsible for regulatory compliance (PRRC)	Dr. Jochen Neuhaus
	PRRC Email	jochen.neuhaus@mint- medical.com
	PRRC Phone	(+49) 6221 32 18 018

The Competent (Regulatory) Authority of your country has been informed about this communication to customers.

Transmission of this Field Safety Notice

This notice needs to be passed on to all users of mint Lesion™ within your organization. Please maintain awareness of this notice and the resulting action for an appropriate period to ensure the effectiveness of the corrective action.

Please report all device-related incidents to the manufacturer, distributor or local representative, and the national Competent Authority if appropriate, as this provides important feedback.

Heidelberg, 2024-10-17

