Tab 5

Validation Parameters #1

predict\_output\_ids = model\_saved.generate(input\_ids\_tensor, min\_length=200, max\_length=400, #TODO set the model

num\_beams=5, no\_repeat\_ngram\_size=3)

Valid 01 - lung cancer

Doctor: Hello! I see that you were referred to our hospital for a lung adenocarcinoma measuring 28 mm in your right upper lobe. Is that correct?

Patient: Yes, that's right.

Doctor: We have planned a UVATS procedure to resect the tumor. Are you familiar with this procedure?

Patient: Not really, can you explain it to me?

Doctor: Of course. During the procedure, you will be placed in the left lateral decubitus position under general anesthesia. We will then make a 4-cm skin incision for the main port in the sixth intercostal space at the anterior axillary line.

Patient: Okay, I see.

Doctor: A wound retractor will be used to allow the insertion of a flexible thoracoscope, endoscopic autosuturing device, and vessel-sealing device via the main port incision. This will also allow us to extract the specimen after the operation.

Patient: Hmm, I understand.

Doctor: During the operation, we found an incomplete interlobar fissure between the upper and middle lobe, as well as abnormal lobulation of the upper lobe. Therefore, we carried out a modified marionette technique.

Patient: What does that involve?

Doctor: First, an Internal organ retractor was inserted into the thoracic cavity using a clip applier. This allowed the retractor to grasp the targeted lung parenchyma properly.

Patient: Okay.

Doctor: Second, we prepared two sets of looped 1-0 nylon-threaded 18-gauge injection needles. These needles were optimally pierced through the thoracic wall separately.

Patient: And then what happened?

Doctor: Finally, both ends of the 1-0 nylon thread attached to the Internal organ retractor were pulled out through the looped nylon. This allowed us to perform the procedure more effectively.

Patient: I see. So, what are the follow-up requirements for this procedure?

Doctor: You will need regular check-ups and monitoring to ensure that the tumor has been completely removed and that there are no complications. We will provide you with more information regarding your follow-up appointments.

Patient: Thank you, doctor. I appreciate the explanation.

Doctor: You're welcome! If you have any more questions, feel free to ask. We're here to help.

Patient: I think I understand everything now. Thanks again.

Doctor: No problem, take care, and we'll see you at your follow-up appointment.

S: The patient confirmed a diagnosis of lung adenocarcinoma in the right upper lobe, measuring 28 mm. The patient expressed unfamiliarity with the planned UVATS procedure and required explanation about the process and follow-up care.

O: During the UVATS procedure, an incomplete interlobar fissure between the upper and middle lobe and abnormal lobulation of the upper lobe were noted. A modified marionette technique was utilized involving the insertion of an internal organ retractor and the use of looped 1-0 nylon-threaded 18-gauge injection needles. The patient was placed in the left lateral decubitus position, and a 4-cm skin incision was made in the sixth intercostal space at the anterior axillary line for the main port.

A: Primary diagnosis is lung adenocarcinoma in the right upper lobe. The UVATS procedure was completed with modifications due to anatomical variations. The assessment during surgery did not indicate any immediate complications from the procedure.

P: The patient is scheduled for regular follow-up appointments to monitor for complete tumor removal and to check for any postoperative complications. The patient will be provided with detailed information regarding the schedule and nature of these follow-ups. Further education on the procedure and postoperative care will be provided as needed to ensure understanding and compliance.

**Model 1**

S: The patient reports being referred for a lung adenocarcinoma measuring 28 mm in the right upper lobe. The patient has not been familiar with the procedure.

O: During the UVATS procedure, the patient was placed in the left lateral decubitus position under general anesthesia, followed by a 4-cm skin incision for the main port in the sixth intercostal space at the anterior axillary line. A wound retractor was used to allow the insertion of a flexible thoracoscope, endoscopic autosuturing device, and vessel-sealing device. Post-surgery, an incomplete interlobar fissure was found between the upper and midlobes of the lung.

A: The primary diagnosis is a recurrent lung tumor with a history of lung cancer. Differential diagnoses could include other causes of lung tumors, but these are less likely given the patient's history and clinical presentation.

P: The management plan includes a UVATS operation to resect the tumor. A follow-up appointment will be scheduled to monitor the progress of the procedure and monitor the tumor's progress."]

**Model Temp 0 and early stopping**

S: The patient reports being referred for a lung adenocarcinoma measuring 28 mm in the right upper lobe. The patient has not been familiar with the procedure.

O: During the UVATS procedure, the patient was placed in the left lateral decubitus position under general anesthesia, followed by a 4-cm skin incision for the main port in the sixth intercostal space at the anterior axillary line. A wound retractor was used to allow the insertion of a flexible thoracoscope, endoscopic autosuturing device, and vessel-sealing device. Post-surgery, an incomplete interlobar fissure was found between the upper and midlobes of the lung.

A: The primary diagnosis is a recurrent lung tumor with a history of lung cancer. Differential diagnoses could include other causes of lung tumors, but these are less likely given the patient's history and clinical presentation.

P: The management plan includes a UVATS operation to resect the tumor. A follow-up appointment will be scheduled to monitor the progress of the procedure and monitor the tumor's progress.

This dialogue is strange as it describes an upcoming procedure, but suddenly, both the doctor and patient began speaking about the procedure in past tense. This may confuse the model.

**Finetuned Flan T5**

["S: The patient is a patient with a history of a left upper lobe adenocarcinoma weighing 28 mm, which was confirmed by the report. The patient was previously unintentional during the initial procedure, and describes the procedure under anesthesia. The plan includes a 3Cm skin incision at the main port in the sixth intercostal space, where the wound retractor was placed. A flexible thoracoscope, endoscopic autosuturing device, and vessel-sealing device were also planned. Post-operative care includes regular monitoring and follow-up appointments to ensure the tumor is cured.

A: The primary diagnosis is to resected a lung adota, using a modified marionette technique. The procedure involved the use of two sets of looped 1-0 nylon-threaded 18-gauge injection needles, with successful completion of the surgery. Differential approaches were considered but were less successful in achieving the goal of resection. The prognosis is cautiously optimistic, as indicated by the patient's response to the procedure and positive assessment from the medical staff.

P: Initiated a planned UVATS procedure to precisely resecrect the thorny portion of the lung artery with careful close monitoring and close communication. During the operation, the patient will be observed for any signs of physical pain or discomfort, and will be advised to report any new symptoms immediately. Further postoperative care will be provided to ensure compliance with the treatment and recovery plan."]

In model 1, the S and O are accurate. S is less descriptive and O is different, but all contain key information. Differente A, but has the key diagnosis of cancer. The original dialogue and truth never mentions cancer, but the model determines ardenocima to be cancer, which is correct. However, it mentions a history of lung cancer, which is not really confirmed in this context. In P, the mode inccorect states that the plan is the UVATS operation, as it has already happened. Although, to be fair to the model, the dialogue switches from future to past tense without warning.

In the fine-tuned model, there is good language, and the summary actually seems accurate, but does not closely follow SOAP structure. Based on prelim model results, overfitting is likely

Valid 02 - eyebrows

Doctor: Hello! You mentioned that you came in for an evaluation and treatment for eyebrow alopecia. Can you tell me more about that and if you've experienced any other hair loss on your body?

Patient: Hi, doctor. Yes, I've noticed my eyebrows have been thinning, but I haven't experienced hair loss anywhere else on my body.

Doctor: Alright. Have you done anything to your eyebrows in the past, like plucking them with tweezers?

Patient: Yes, I used to shape my eyebrows by plucking them with tweezers.

Doctor: Do you have any other medical conditions or concerns that you'd like me to be aware of?

Patient: No, I don't have any other medical conditions.

Doctor: Okay, let me examine your eyebrows and other areas on your body to check for any signs of alopecia. \*Examines patient\* I see sparse and thin black hairs on your eyebrows but no signs of hair loss elsewhere, such as your frontal hairline or temporal area.

Patient: That's good to hear.

Doctor: Based on my examination, I'm diagnosing you with idiopathic eyebrow hypotrichosis. I'm going to prescribe you a bimatoprost 0.03% solution to apply to the affected areas daily.

Patient: Okay, thank you.

Doctor: Just so you know, improvement in your eyebrow hypotrichosis will be gradual, so you'll need to be patient. I'd like to see you for periodic follow-up visits every two months to monitor your progress.

Patient: Alright, that sounds reasonable.

Doctor: \*During follow-up visits\* How has your compliance with the daily application of the bimatoprost 0.03% solution been?

Patient: I've been using it once a day as you instructed.

Doctor: Great! I can see increased hair growth and thickening of your eyebrow hairs. Have you experienced any treatment-associated side effects?

Patient: No, I haven't had any side effects from the treatment.

Doctor: That's excellent! After eight months, it looks like you have complete regrowth of your eyebrows. We'll continue with the daily topical treatment of bimatoprost 0.03% solution to maintain these results.

Patient: Thank you, doctor. I'm really happy with the progress and the treatment.

S: The patient, a female with no significant medical history, presented with the chief complaint of eyebrow thinning, specifically noting no other areas of hair loss on her body. She reported a history of eyebrow plucking, which could be relevant to her current condition.

O: Physical examination revealed sparse and thin black hairs on the eyebrows with no signs of hair loss on the frontal hairline or temporal areas. No other abnormalities were noted during the examination. The patient has been using bimatoprost 0.03% solution daily as prescribed, with no reported side effects.

A: The primary diagnosis is idiopathic eyebrow hypotrichosis. The patient's history and clinical findings support this diagnosis, with no evidence of other dermatological or systemic diseases contributing to the hair loss. The prognosis is good, given the positive response to treatment observed during follow-up.

P: The management plan includes continued daily application of bimatoprost 0.03% solution to the affected areas to maintain hair regrowth. The patient is scheduled for periodic follow-up visits every two months to monitor progress and adherence to the treatment regimen. Education on the gradual nature of treatment response and encouragement of patient compliance have been emphasized. No referral to other specialties is needed at this time.

S: The patient reports noticing thinning eyebrows but has not experienced hair loss elsewhere on the body. The patient has a history of plucking eyebrows with tweezers. No other medical conditions or concerns were reported.

O: Physical examination revealed sparse and thin black hairs on the eyebrows, with no hair loss at the frontal hairline or temporal area. Laboratory tests showed alopecia with a white blood cell count of 95% on the thigh, and a hemoglobin level of 11% on the right hemisphere.

A: The primary diagnosis is hair loss in the forehead, frontal, and temporal areas. Differential diagnoses could include other causes of hair loss, but these are less likely given the imaging findings.

P: The management plan includes a follow-up appointment to monitor the patient's condition and any other concerns. Follow-up appointments will be scheduled to assess the severity of the hair loss. A

S: The patient reports noticing thinning eyebrows but has not experienced hair loss elsewhere on the body. The patient has a history of plucking eyebrows with tweezers. No other medical conditions or concerns were reported.

O: Physical examination revealed sparse and thin black hairs on the eyebrows, with no hair loss at the frontal hairline or temporal area. Laboratory tests showed alopecia with a white blood cell count of 95% on the thigh, and a hemoglobin level of 11% on the right hemisphere.

A: The primary diagnosis is hair loss in the forehead, frontal, and temporal areas. Differential diagnoses could include other causes of hair loss, but these are less likely given the imaging findings.

P: The management plan includes a follow-up appointment to monitor the patient's condition and any other concerns. Follow-up appointments will be scheduled to assess the severity of the hair loss. A"]

["S: The patient, with a history of idiopathic eyebrow alopecia, reports noticing thinning eyebrows but no other areas of body hair loss. The patient has used to throw their eyebrows using tweezers.

O: Physical examination revealed sparse and thin black hairs on the eyebrows with no signs of hair loss outside of the frontal hairline or temporal area. Recent application of bimatoprost 0.03% on the affected eyebrows has been successful, showing increased hair growth and thickening of the eyebrow hairs. Follow-up visits have been scheduled for every two months to monitor the patient's progress. No specific findings or side effects have been observed associated with the daily topical treatment.

A: Primary diagnosis is idipiopathic oblique eyebrow hypotrichosis, as the patient has been using the treatment with minimal side effects and compliance. Differential diagnosis includes other causes of obligiosis and phenylinolysis, but these are less likely given the specific findings and regular follow-ups.

P: Initiated daily use of the medication and expects to continue the treatment for at least 8 months to complete regrowth of eyebrows. Plan to continue monitoring the patient closely for any new or worsening of symptoms. Encourage the patient to report any new symptoms promptly to improve compliance. Educate the patient on the importance of adherence to the treatment instructions and adhering to the instructions for daily use."]

In O, the model has completely made up laboratory tests. No imaging nor blood tests where done, only physical examination. This was completely hallucinated. Alopecia diagnosis is slightly off from the more accurate diagnosis of hypertrichosis. In A, the model contradicts the findings in O – there is no hair loss anywher but the eyebrows. Again, no imaging tests were conducted. In P, it should state multiple follow ups every 2 months, which is key information. No mention of the topical medicine was mentioned either

In the next iteration, it does not seem that lowering the temperature is very effective at preventing hallucination.

In the flan model, this looks pretty good. P fails to mention the medication name.

Valid 03 - Afib

Doctor: Good morning, ma'am. I see you were admitted to the emergency department with a complaint of palpitations that started a few hours ago. Can you describe the palpitations for me?

Patient: Hi, doctor. Yeah, my heart has been beating really fast and irregularly for the past few hours. It's quite uncomfortable.

Doctor: I understand. We've done a 12-lead ECG, which suggests that you have atrial fibrillation. I also noticed in your medical history that you've been taking oral anticoagulation therapy for recurrent episodes of atrial fibrillation and topiramate for essential tremor in your arms. Is that correct?

Patient: Yes, that's right. I've had these issues before, and the medications help manage them.

Doctor: After you were admitted, we administered an intravenous dose of amiodarone to help with your current symptoms. Your new 12-lead ECG is now compatible with atrial flutter, having a cycle length of 240 ms and a 4:1 atrioventricular response.

Patient: Oh, okay. What does that mean?

Doctor: Atrial flutter is a different type of abnormal heart rhythm, but it's related to atrial fibrillation. The cycle length and atrioventricular response we observed indicate that your heart rhythm has changed, but it's still not regular.

Patient: I see. So, what's the next step?

Doctor: We wanted to further evaluate the underlying heart rhythm, so we performed a two-dimensional transthoracic echocardiography (2D TTE) on you. This is an ultrasound of your heart to see how it's functioning.

Patient: And what did you find?

Doctor: We measured the transmitral flow using pulsed-wave Doppler and found a diastolic pattern with a normal atrial rhythm. This means that your heart is functioning relatively well despite the abnormal rhythm.

Patient: That's a relief. What do we do now?

Doctor: We will continue to monitor your heart rhythm and adjust your medications as needed. It's important for you to keep taking your prescribed medications and follow up with your cardiologist regularly for further evaluation and management.

Patient: Alright, doctor. I appreciate your help. I'll make sure to follow up with my cardiologist and take my medications as prescribed.

Doctor: You're welcome. If you experience any worsening symptoms or have any concerns, do not hesitate to contact your healthcare team or come back to the emergency department. Take care and stay safe.

S: The patient, a female with a history of recurrent atrial fibrillation and essential tremor, presented to the emergency department with palpitations described as fast and irregular, which started a few hours prior to admission. She reports discomfort associated with these symptoms. The patient confirms ongoing treatment with oral anticoagulation therapy and topiramate.

O: Initial 12-lead ECG indicated atrial fibrillation. Post-administration of intravenous amiodarone, a follow-up 12-lead ECG showed atrial flutter with a cycle length of 240 ms and a 4:1 atrioventricular response. Two-dimensional transthoracic echocardiography (2D TTE) revealed a diastolic pattern with a normal atrial rhythm, indicating relatively good cardiac function despite the abnormal rhythm.

A: The primary diagnosis is atrial flutter, previously managed as atrial fibrillation. The patient's heart function is stable as evidenced by the 2D TTE findings, but the presence of atrial flutter necessitates ongoing monitoring and possible adjustment of her current therapeutic regimen.

P: Continue monitoring the patient's heart rhythm and adjust medications as necessary. The patient is advised to adhere strictly to her prescribed medication regimen and schedule regular follow-up visits with her cardiologist. She is also instructed to seek immediate medical attention if symptoms worsen or new concerns arise.

S: The patient, a female with a history of atrial fibrillation treated with oral anticoagulation therapy and topiramate, presented with palpitations that started a few hours ago. She described the palpations as fast and irregular. She was previously treated with amiodarone, which was administered intravenously.

O: The 12-lead ECG showed atrial flutter with 240 ms cycle length and a 4:1 atrioventricular response. The patient's previous medications include a recurrent episode of adipose tissue thrombocytopenia, and tachycardia.

A: The primary diagnosis is a diastolic heart disease (TBS), characterized by rapid heart beats and irregular heart rhythms. Differential diagnoses could include other causes of heart failure, but these are less likely given the clinical presentation and clinical presentation.

P: The management plan includes discontinuation of the medication and reintroduction of the symptom management plan. The plan includes a follow-up appointment to monitor the patient’s heart rate and heart rate, and the patient will be monitored for any changes in heart rate or heart rate. Follow-up appointments will be scheduled to monitor

['S: The patient, a chronic patient with a 12-lead ECG presenting with palpitations for the past few hours, describing the discomfort as "very fast and irregularly" for the patient. The patient has been taking oral anticoagulation therapy for recurrent episodes of atrial fibrillation and topiramate for essential tremor in arms.

O: Initial evaluation of the patient\'s heart function using an intravenous dose of amiodarone indicated atrial flutter. Recent ECG measurements showed a cycle length of 240 ms and a normal atrioventricular response. Laboratory findings indicated a diastolic pattern with normal atrial rhythm and ultrasound echocardiography.

A: The primary diagnosis is acute cardiac arrhythmias, likely associated with arrhythmic fibrilation. Differential causes of heart rhythm disturbances necessitated monitoring and adjustment of current medications. The prognosis is favorable with recommendations for heart management.

P: Continue monitoring the cardiac function with regular follow-up appointments and adjust heart medications as needed. Maintain current medications and pulsed-wave Doppler are essential. Monitoring of the heart muscle is essential to manage symptoms and prevent heart complications. The importance of monitoring heart function is underscored.']

In S, the patient did use topiramate in her past, but for essential tremor, not afib. Othewrwise, key information is there, but could be more descriptive, does not mention feeling of discomfort. In O, medications should not be mentioned. Here it mentions medical diagnoses as medications, which is highly odd. Tachycardia is mentioned, while afib is tachycardic, it is not really an effective description. Thrombocytopenia is completely made up. The echocardiogram is not even mentioned. In A, atrial flutter is not mentioned, which is key. Heart failure is brought up, and although a form of heart disease, quite different from atrial dysrhythm. In P, incorrectly states to discontinue medication. Repetitive language occurs.

In Flan, I believe pulse wave doppler refers to echocardiogram, but this is not a P item.

Valid 04 - ecchymosis

Doctor: Hello, I see that you were admitted to our hospital due to ecchymosis on both lower extremities. Can you tell me more about your medical history?

Patient: Yes, three years before admission, I was diagnosed with ITP through laboratory tests, including antibodies against platelet glycoprotein IIb/IIIa and GP IV, and bone marrow aspiration. I was treated successfully with corticosteroids. I also have a history of nontuberculosis mycobacterial infection.

Doctor: I see. What treatment were you on before coming here?

Patient: I was taking prednisolone, clarithromycin, rifampicin, and ethambutol hydrochloride.

Doctor: Okay. I have your recent examination results here. Two weeks before admission, your platelet counts were normal, at 185 × 10^9/l. However, on admission, your laboratory findings showed a significant drop in platelet count, to 3.0 × 10^9/l. Your biochemical parameters and coagulation values were within the normal limit, and antibodies against Helicobacter pylori, hepatitis C virus, hepatitis B virus, and HIV were negative. Based on this, we diagnosed you with acute exacerbation of chronic ITP.

Patient: Oh, no. What will be my treatment now?

Doctor: We started you on high-dose IVIG, PSL (40 mg/day), and romiplostim (1 µg/kg). However, during the next four days, you developed respiratory failure with a PaO2/FiO2 ratio of approximately 250. We performed a computed tomography (CT) on the fourth day of hospitalization, which revealed ground-glass opacities with marginal infiltration in both lung fields. This led us to diagnose you with alveolar hemorrhage.

Patient: That's terrible. What happened next?

Doctor: As your dyspnea worsened gradually, we initiated noninvasive positive pressure ventilation (NPPV) to help you breathe. On the 11th day of hospitalization, we increased the dose of romiplostim to 10 µg/kg and administered pulsed doses of methyl-PSL (1000 mg/day for 3 days) along with a second cycle of IVIG.

Patient: Did that help?

Doctor: Yes, by the 21st day of hospitalization, your platelet count recovered, and you were discharged without any complications.

Patient: That's a relief. What's my current situation?

Doctor: Your platelet count has remained normal while being treated with 12.5 mg of prednisolone. We will continue to monitor your condition and adjust your treatment as necessary. Make sure to attend any follow-up appointments and report any new symptoms or concerns.

Patient: Thank you, doctor. I appreciate your help and will make sure to follow your instructions.

S: The patient, previously diagnosed with Immune Thrombocytopenia (ITP) and treated with corticosteroids, was admitted with ecchymosis on both lower extremities. The patient reported a history of nontuberculosis mycobacterial infection and was on prednisolone, clarithromycin, rifampicin, and ethambutol hydrochloride prior to admission.

O: On admission, the patient's platelet count was significantly reduced to 3.0 × 10^9/l from a previous normal count of 185 × 10^9/l. Biochemical parameters and coagulation values were normal. Tests for Helicobacter pylori, hepatitis C and B viruses, and HIV were negative. CT imaging on the fourth day showed ground-glass opacities with marginal infiltration in both lung fields, indicative of alveolar hemorrhage. The patient developed respiratory failure with a PaO2/FiO2 ratio of approximately 250.

A: The primary diagnosis is an acute exacerbation of chronic ITP, complicated by alveolar hemorrhage. The patient's history of ITP and recent exacerbation, along with the development of respiratory complications, guided the diagnosis and treatment.

P: Treatment initiated with high-dose IVIG, PSL (40 mg/day), and romiplostim (1 µg/kg), escalated to 10 µg/kg due to worsening condition. Pulsed doses of methyl-PSL (1000 mg/day for 3 days) and a second cycle of IVIG were administered. Noninvasive positive pressure ventilation (NPPV) was used for respiratory support. The patient's treatment will continue with monitoring and adjustments as necessary, including maintaining a dose of prednisolone at 12.5 mg. Follow-up appointments are scheduled to monitor the patient's condition and platelet count.

**Model 1**

S: The patient, admitted due to ecchymosis on both lower extremities, reports a history of ITP diagnosed three years ago through laboratory tests including antibodies against platelet glycoprotein IIb/IIIa and GP IV, bone marrow aspiration, and nontuberculosis mycobacterial infection. The patient was previously treated with corticosteroids and prednisolone, clarithromycin, rifampicin, and ethambutol hydrochloride.

O: On examination, platelet counts were normal at 185 109/l. Biochemical parameters and coagulation values were within normal limits, and antibodies against Helicobacter pylori were within the normal limit. Laboratory findings showed a significant drop in platelet count to 3.0 109/10/l, with normal hemoglobin levels and antigen levels. Immunohistochemistry was within normal ranges. CT scan revealed a squamous cell carcinoma (SCC) in the left upper extremity.

A: The primary diagnosis is SCC based on the clinical presentation and clinical presentation. Differential diagnoses could include other causes of SCC

**Flan**

['S: The patient, a 45-year-old male, presented with ecchymosis on both lower extremities, presenting with acute exacerbation of chronic ITP (ITP) through laboratory tests including antibodies against platelet glycoprotein IIb/IIIa and GP IV, and bone marrow aspiration. He reported treatment with corticosteroids and a history of nontuberculosis mycobacterial infection previously treated with prednisolone, clarithromycin, rifampicin, and ethambutol hydrochloride. Recent examination revealed two weeks of normal platelet counts, normal at 185 109/l, with a significant decrease in platelet count to 3.0 10-9 l. Biochemical parameters and coagulation values were within normal limits, and antibodies against Helicobacter pylori, hepatitis C virus, hempatit']

S looks good. Generally does look good. In O, again, making up diagnosis that are not there

Flan seems inconsistent. Often compltely mising the separation of SOAP. 2 weeks ago, should not be for 2 weeks.

Valid 05 -

Doctor: Hello, I see you've been admitted to our clinic for delivery at the 37th week of your gestation. Can you tell me a bit about your pregnancy history?

Patient: Sure, this is my sixth pregnancy. I have two children and had three abortions. I also had one previous cesarean section delivery.

Doctor: Thank you for sharing that. I have your preoperative blood test results here. Your hemoglobin is 10.8 g/dL, prothrombin time (PT) is 10.5 seconds, activated partial thromboplastin time (aPTT) is 29 seconds, international normalized ratio is 2.3, and platelet count is 385x109/L.

Patient: Hmm, okay.

Doctor: We also performed a transabdominal sonography and magnetic resonance imaging on you. The results show total placenta previa and myometrial invasion to the urinary bladder at the anterior wall of your uterus.

Patient: Oh, that sounds concerning.

Doctor: Yes, it can be. You mentioned earlier that you would prefer a conservative approach rather than hysterectomy in case of massive bleeding, is that correct?

Patient: Yes, that's right.

Doctor: After the cesarean delivery of your baby through a Pfannenstiel incision and removal of the placenta, we detected a 5-6 cm area of tissue loss at the anterior wall of the uterus. There was also bleeding from the cervix and posterior wall of the bladder.

Patient: Oh no, what did you do?

Doctor: We applied pelvic packing on the pelvic vessels for 20 minutes and sutured the bleeding sites with 1.0 polyglactine sutures. We also placed a Sengstaken-Blakemore balloon catheter in the uterus before suturing.

Patient: And did that help?

Doctor: We filled the stomach balloon with 250 mL saline and the esophageal balloon with 400 mL saline to provide compression on the lower uterine isthmic and cervical bleeds. However, bleeding continued.

Patient: What happened next?

Doctor: Bilateral uterine and hypogastric artery ligations were planned due to the hemorrhage. During the procedure, the left external iliac artery was accidentally held and bonded as the left hypogastric artery, but we released it within a minute after distinguishing the vessels.

Patient: Oh, I see.

Doctor: Following that, we successfully ligated the uterine and hypogastric arteries on both sides. You lost about 2000 cc of blood due to the intraoperative hemorrhage, which we measured by adding 1650 cc blood in the aspirator and counting the gauzes.

Patient: That's a lot of blood.

Doctor: Yes, it is. We gave you erythrocyte suspension (3 units preoperatively and 4 unites postoperatively) and 3 packs of fresh frozen plasma to help with the blood loss.

Patient: Thank you, doctor. I appreciate all that you did to help me during the delivery.

S: The patient, a 37-week pregnant woman with a history of two live births, three abortions, and one previous cesarean section, presented for delivery. She expressed a preference for conservative management over hysterectomy in the event of massive bleeding.

O: Hemoglobin was 10.8 g/dL, prothrombin time (PT) 10.5 seconds, activated partial thromboplastin time (aPTT) 29 seconds, international normalized ratio (INR) 2.3, and platelet count 385x10^9/L. Imaging revealed total placenta previa and myometrial invasion into the urinary bladder. During cesarean delivery, a 5-6 cm area of tissue loss at the anterior wall of the uterus was noted, with bleeding from the cervix and posterior bladder wall. Pelvic packing and suturing were performed, followed by placement of a Sengstaken-Blakemore balloon catheter. Despite these measures, bleeding continued, leading to bilateral uterine and hypogastric artery ligations. The patient lost approximately 2000 cc of blood. She received 3 units of erythrocyte suspension preoperatively and 4 units postoperatively, along with 3 packs of fresh frozen plasma.

A: The patient was diagnosed with total placenta previa and myometrial invasion, complicated by significant intraoperative hemorrhage. The accidental temporary bonding of the left external iliac artery was promptly corrected. The patient's condition stabilized following the surgical interventions.

P: Continue monitoring hemoglobin levels and coagulation parameters closely. Administer iron supplements and consider additional blood transfusions if necessary. Provide postoperative care including pain management and infection prevention. Schedule follow-up appointments for wound care and psychological support considering the traumatic nature of the delivery. Educate the patient on signs of infection or complications to watch for during recovery.

**FLan t5**

["S: The patient, a 6-year pregnant woman, reports a history of two children, three abortions, and a previous cesarean section delivery. She mentions using hysterectomy for massive bleeding and using pelvic packing for 20 minutes.

O: Preoperative blood tests show hemoglobin at 10.8 g/dL, PT at 10.5 seconds, akt total thromboplastin time (aPTT) at 29 seconds, and platelet count at 385x109/L. Transabdominal sonography and magnetic resonance imaging confirmed total placenta previa and myometrial invasion to the urinary bladder at the anterior wall of the uterus. Local anastomosis revealed total uterine isthmic and cervical bleeding, but no signs of coagulation or bleeding from the cervix.

A: The primary diagnosis is severe hemorrhage post-succesive labor, managed by surgical venous and esophagectomy. The patient's current hematocrit is within normal limits, suggesting ongoing bleeding and potential complications.

P: The management plan includes adherence to a prenatal diet specific for hemolysis to prevent excessive bleeding and to eat disorders like antacid bolus. The plan includes regular follow-up appointments to monitor for any recurrence or complications from the delivery. Blood pressure and creatina related to the bilirubin levels should be maintained to prevent further ovulation. Patient education on signs of potential complications and lifestyle adjustments to cope with recurrent contractions is crucial."]

In Flan, the actual diagnosis is listed as an objective finding, but should fall under A.