OE ORDER
ADM-20240816-0019
Assign to Physician: RAMGE
Patient Status: IP:Admit to Inpatient
Medical Reason: Admit to LD6.Ped is OC

HISTORY AND PHYSICAL
Admit Note - Brief - 08-16-2024

Free Text A P:
OB HISTORY AND PHYSICAL

This is a Spanish-speaking 28-year-old gravida 1 para 0 at 39 weeks 6 days gestation based on an EDD of 08/17/2024.She has had prenatal care in our office since 11 weeks gestation and had an early ultrasound confirming the due date. Her prenatal course has been uncomplicated.

She presents with a complaint of leakage of fluid. She is found to be grossly ruptured with thick meconium. On nurse's exam she is found to be vertex with dilation of 3-4 cm 80% -2 station.

Allergies: No known drug allergies

Medications: Prenatal vitamin

Past medical history: Denies

Past surgical history:
Denies

Social history:
What is your relationship status: Married
Are you sexually active: Yes
Do you or have you ever smoked tobacco: Never smoker

Do you or have you ever used any other forms of tobacco or nicotine: No
Has tobacco cessation counselling been provided: No
What is your level of alcohol consumption: None
Do you use any illicit or recreational drugs: No
What is your level of caffeine consumption: None
Ethnic Background: Hispanic or Latinx
History of domestic violence: No
Spouse/Partners Name: Wildi
What type of diet are you following: Regular

What is your exercise level: None
What is the highest grade or level of school you have completed or the highest degree you have received: High school graduate
Are you currently in school: No
Are you currently employed: No
Do you have an advance directive: No
Is blood transfusion acceptable in an emergency: Yes
Have you recently travelled abroad: No
Are you passively exposed to smoke: No
Last modified by estrassner
03-28-2024, 09:28

Gender Identity and LGBTQ Identity
Gender identity: Identifies as Female
Pronouns: she/her
Sexual orientation: Straight or heterosexual

REVIEW OF SYSTEMS:
General: Denies fever, chills, fatigue
HEENT: Unremarkable
Respiratory: Denies chest pain shortness of breath difficulty breathing dyspnea on exertion
Cardiac: Denies chest pain, palpitations, orthopnea.
GI: Denies nausea vomiting diarrhea or constipation
GU: Denies dysuria frequency urgency or hematuria
Neurologic: Denies headache visual change unusual weakness numbness Psychiatric:
Denies significant anxiety or depression at this time

PHYSICAL EXAM:
General: Alert, Conversive, Cooperative, in no acute distress
HEENT: Unremarkable
Lungs: Clear to auscultation bilaterally no rales rhonchi or wheezing Heart:
Regular rate and rhythm without murmurs gallops rubs or thrills.
Abdomen: Soft, gravid, nontender, no rebound guarding or rigidity
Extremities: No clubbing cyanosis or edema calves are nontender without varicosity.
Neurologic: There are no gross motor sensory deficits noted on exam.
Pelvic exam: Deferred at this time

Fetal assessment: Category 1 tracing, estimated fetal weight 9-9.5 lb

Impression: Intrauterine pregnancy at 39 weeks gestation,

Plan:
Admit to Labour and delivery with expectant management. Prenatal record reviewed and placed on chart recent ultrasound reviewed. I discussed the possibility of fetal macrosomia

with the patient and we will monitor closely in labor. She understands that there is an increased risk for C-section if she develops CPD.

PROGRESS NOTE
Clinical note - 08-16-2024

Clinical Note:
Patient doing well after epidural anesthesia. She has made progress from 05/10 now 9 cm and +2 station. There is minimal caput with some mild molding. Pitocin is at 21 milli units and contractions seemed to be adequate. Fetal heart rate tracing: Category 1 Vitals are stable and patient is tolerating labour well.

Clinical Note:
Note: SVE 8 cm with swelling at the cervix and caput
No change in station
Contractions have been adequate
Fetal heart rate category 1
I discussed the changes with the patient and the lack of progress as well. We discussed further induction and expectant management and rechecking an hour versus proceeding to C-section for CPD. After going over the risk and benefits potential complications and consequences of each he wishes to proceed with a C-section now. Nursing informed Anesthesia informed and OR informed.

LABOR AND DELIVERY NOTE
OB postpartum progress note - 08-17-2024

Physical Exam:
Cardiac: normal rhythm, no clinically sig murmur Lungs:
clear to auscultation, unlabored breathing Neuro:
Exam: alert, oriented x3, normal speech, normal gait, CNII-XII grossly intact
Abdomen: soft, normoactive bowel sounds
Incision site: dressing clean dry
Uterus: firm, involution appropriate
Fundus: firm, below the umbilicus
Lochia: normal Lower extremities:
Edema: trace
Calf tenderness: negative

Laboratory Tests:
08/17 08/17
0811 0424
Hematology
WBC (4.8 - 10.8 K/MM3) 26.1 H 28.7 H

RBC (3.80 - 5.50 MIL/MM) 2.81 L 2.94 L
Hgb (11.7 - 15.5 GM/DL) 6.2 CL 6.6 CL
Hct (33.0 - 45.0 %) 19.5 CL 20.4 CL
MCV (78 - 100 fL) 70 L 69 L
MCH (28.0 - 34.0 PG) 22.1 L 22.5 L
MCHC (32.0 - 36.0 g/dL) 31.8 L 32.4
RDW (11.5 - 14.5 %) 19.3 H 19.2 H
Plt Count (130 - 400 K/MM3) 288 303
MPV (6.0 - 9.5 UM3) 8.8 9.1
Neut % (Auto) (45.0 - 75.0 %) 86.1 H 92.3 H
Lymph % (Auto) (20 - 40 %) 5.1 L 3.4 L
Mono % (Auto) (0 - 10.5 %) 8.4 4.1
Eos % (Auto) (0 - 7 %) 0.1 0.0
Baso % (Auto) (0 - 2.0 %) 0.3 0.2

Diagnosis, Assessment Plan:
Free text A P:
PPD #1

Patient is without complications. Decreasing lochia. Patient voiding without difficulty. Patient denies any light-headedness or dizziness. Vital signs reviewed.

A/P:
Status PPD1 via PC/S, Doing well. Acute blood loss anemia. Hemoglobin 9 down to 6.2 will give 1 unit of packed red blood cells repeat CBC 4 hours post transfusion Routine post-partum care. All questions answered to her satisfaction.
Babies doing well

Assessment: acute blood loss anemia
Plan: routine postpartum care, discharge tomorrow

OB Discharge postpartum - 08-18-2024

Subjective:
Admission EGA:
Weeks: 39
Status/day: post partum (2), post operative (2)

Vital Signs:
Date Temp Pulse Resp B/P B/P Mean Pulse Ox FiO2
08/17-08/18 36.4-36.9 84-97 16-20 104-112/58-71

Last Documented:
Result Date Time

Resp 16 08/18 0322
Pulse 84 08/18 0322
Temp 36.6 08/18 0322
B/P 104/68 08/18 0322
Pulse Ox 98 08/17 0526

PATIENT WEIGHT:
Weight (lb): 195 Weight
(oz):
Weight (kg): 88.450513

Physical Exam:
Cardiac: normal rhythm, no clinically sig murmur Lungs:
clear to auscultation, unlabored breathing Neuro:
Exam: alert, oriented x3, normal speech, normal gait, CNII-XII grossly intact
Abdomen: post gravid, soft, no abnormal tenderness
Incision site: dressing clean dry
Uterus: involution appropriate
Fundus: firm, below the umbilicus
Lochia: normal Lower extremities:
Edema: trace
Calf tenderness: negative

Laboratory Tests:
08/18 08/17 08/17 08/17
0532 1419 0811 0424
Hematology
WBC (4.8 - 10.8 K/MM3) 19.1 H 22.6 H 26.1 H 28.7 H
RBC (3.80 - 5.50 MIL/MM) 3.00 L 3.03 L 2.81 L 2.94 L
Hgb (11.7 - 15.5 GM/DL) 7.1 L 7.1 L 6.2 CL 6.6 CL
Hct (33.0 - 45.0 %) 21.8 L 21.9 L 19.5 CL 20.4 CL
MCV (78 - 100 fL) 72 L 72 L 70 L 69 L
MCH (28.0 - 34.0 PG) 23.7 L 23.5 L 22.1 L 22.5 L
MCHC (32.0 - 36.0 g/dL) 32.8 32.5 31.8 L 32.4
RDW (11.5 - 14.5 %) 20.4 H 20.8 H 19.3 H 19.2 H
Plt Count (130 - 400 K/MM3) 280 275 288 303
MPV (6.0 - 9.5 UM3) 8.6 8.7 8.8 9.1
Neut % (Auto) (45.0 - 75.0 %) 79.1 H 82.0 H 86.1 H 92.3 H
Lymph % (Auto) (20 - 40 %) 12.6 L 8.8 L 5.1 L 3.4 L
Mono % (Auto) (0 - 10.5 %) 6.8 8.6 8.4 4.1
Eos % (Auto) (0 - 7 %) 0.7 0.1 0.1 0.0
Baso % (Auto) (0 - 2.0 %) 0.8 0.5 0.3 0.2

Free Text A P:
Post C section Delivery Discharge Summary

Doing well, ambulating without difficulty, voiding without difficulty, + Flatus, tolerating regular diet, denies increased bleeding, PO analgesia is effective for pain management. Mood stable, denies signs or PP depression.

Vital signs reviewed and are stable, she is afebrile

Assessment:
Status post Repeat c section, recovering well and ready for discharge
Acute blood loss anemia
Post 1 unit blood transfusion hgb 9.0->6.6 >6.2>7.1 after infusion, patient is asymptomatic

Plan:
Discharge home today started
on iron b.i.d.
Patient will shower and remove dressing prior to discharge

Discharge to: home
Discharge condition: stable
Instructions:
Routine instr sheet given, instr and warnings rev'd, Our standard postpartum instructions and precautions were given. She was asked to review the postpartum section of our prenatal booklet. She is to notify us if fever greater than 100.4, increasing pain, or bleeding problems. She is aware of breastfeeding assistance available. She is to call our office for any concerns or problems
Diet: regular
Activity: non-strenuous, may shower
Contraception: advised to review this section in our book, will discuss at PP visit.

Discharge meds:
Prescriptions: e-prescribe
Rx drug database reviewed: yes
Return to work/school: No

Discharge diagnosis:
full-term uncomp delivery
Discharge management: less than 30 mins

Admission diagnosis: anemia
Hospital course: primary cesarean admit, blood transfusion, nml postop/postpart care
Procedures: primary CS delivery
Discharge condition: stable

Discharge to: Home/Self Care
Discharge diagnosis: full-term uncomp delivery, anemia
Plan: routine postpartum care, discharge tomorrow

OB postpartum progress note - 08-19-2024

Subjective:
Free Text Subj Notes:
Post-op Day 3

Patient without complaints. Decreasing lochia.
PE:
Vital Signs Stable, afebrile, fundus just below umbilicus

ABD: Soft, incision clean, dry, intact, appropriately tender to palpation

Vagina: normal lochia

Extremities: Without edema, cyanosis or clubbing, NT

A/P: S/P Primary C Section. Doing well. Proceed with dc home.

BRIEF OPERATIVE REPORT

Preoperative diagnosis: Intrauterine pregnancy at 38 weeks gestation Cephalopelvic disproportion with arrest of descent and dilatation

Postoperative diagnosis: Same as above

Procedure performed: Primary low transverse cesarean section

Anesthesia: Epidural

EBL: 800 cc

Findings: Normal uterus tubes ovaries

Specimen: None

Complications:
Brief atony responsible for excess blood loss responded to doubling of Pitocin fundal massage and Cytotec 800 mg p.o.

Technique in detail:
With informed consent obtained the patient was brought to the operating room where she was sterilely prepped and draped under spinal anesthesia in a supine position. A brief timeout was performed identifying the patient the procedure and all other required components. We then proceeded.

After checking the adequacy of anesthesia with a rat-tooth pick up. The low-transverse incision was created on the abdomen and carried through to the underlying fascia. Fascia was incised transversely in the midline and extended laterally on the left and right with Mayo scissors. Two Kocher clamps were attached to the superior cut edge of the fascial incision. The underlying rectus muscle was dissected off with sharp and blunt dissection. Bovie cautery was used throughout to achieve hemostasis. At the superior aspect of the midline Rossi the hemostat was used to enter the peritoneal cavity. With blunt dissection the rectus muscles were opened with traction laterally. A bladder blade was then inserted over the lower incision. Pickups were used to elevate the vesicouterine peritoneal fold which was incised undermined and incised transversely. The bladder was then dissected off the lower uterine segment with sharp and blunt dissection.

A clean scalpel was then used to create a low-transverse incision on the lower isthmal portion of the uterus, the incision was extended bilaterally with traction. The amniotic membranes were bluntly ruptured. The amniotic fluid coming out was found to be clear.

The operator's hand was then placed under the infant's head the infant's head was elevated into the incision and with mild fundal pressure the infant was completely delivered onto the surgical field. The nasal oropharynx was copiously suctioned. The cord was then doubly clamped and cut. The infant was taken to the awaiting nursery team.

Cord blood was then collected in a test tube for the usual studies. A segment of cord was then collected for cord blood gases if needed. At this time the operator's hand was placed in the cavity of the uterus where the placenta was manually sheared, the placenta was placed in a basin and removed from the field.

The uterus was exteriorized and wiped clear of all clots and debris with a wet lap sponge. Uterus tubes and ovaries were inspected and found to be in normal condition. A 1.Chromic suture was now used in a running and interlocking fashion to reapproximate the uterine edges. A 2nd #1 Chromic suture was used in a running fashion to imbricate the 1st layer. At this time the posterior cul-de -sac was copiously suction irrigated.

The uterus was returned to the pelvic cavity. The incision was inspected and found to be hemostatic. The bladder blade was reinserted and a Richardson retractor was used to retract cephalad while we copiously suction irrigated the left and right paracolic gutters. At this time the cut edges of the parietal peritoneum were placed in a Kelly clamp. A running 2 0 Vicryl suture was used to reapproximate the parietal peritoneum and the leading edges of the rectus muscle to the midline in a running fashion. The muscle layer was then copiously suction

irrigated and Bovie cautery used for additional hemostasis. The fascia was reapproximated from the lateral angles to the midline on the left and right with a # 1 Vicryl suture in a running fashion, Camper's fascia and the subcutaneous adipose tissue were then reapproximated with a running 2- 0 plain gut suture. A 4-0 Monocryl suture was then used in a subcuticular fashion to reapproximate the skin edges. A sterile dressing was then applied. The patient was cleansed and returned to recovery in stable condition. Lap sponge needle and instrument counts were correct x3.

ORDER - DNR

RESUS-20240816-0011
FC: Full Code