PREOPERATIVE DIAGNOSES: , Term pregnancy, nonreassuring fetal heart tracing.,POSTOPERATIVE DIAGNOSES: , Term pregnancy, nonreassuring fetal heart tracing.,OPERATION:, Primary cesarean section by low-transverse incision.,ANESTHESIA:, Epidural.,ESTIMATED BLOOD LOSS: , 450 mL.,COMPLICATIONS: , None.,CONDITION: , Stable.,DRAINS: ,Foley catheter.,INDICATIONS: , The patient is a 39-year-old, G4, para 0-0-3-0, with an EDC of 03/08/2009. The patient began having prodromal symptoms 2 to 3 days prior to presentation. She was seen on 03/09/2007 and a nonstress test was performed. This revealed some spontaneous variable-appearing decelerations. She was given IV hydration. A biophysical profile was obtained, which provided a score of 0/8 with only a 1 cm fluid pocket found. Therefore, she was admitted for further fetal monitoring and evaluation. She had changed her cervix from closed 2 days prior to presentation to 1 cm dilated. She was having somewhat irregular contractions, but with stronger contractions, continued to have decelerations to 50 to 60 beats per minute. Due to these findings, a scalp electrode was placed as well as an IUPC for an amnioinfusion. This relieved the decelerations somewhat. However, over a period of time with strong contractions, she still had bradycardia 40 to 50 beats per minute and developed a late component on the return of the decelerations. Due to this finding, it was evident that the fetal state would not support labor in order to accomplish a vaginal delivery. These findings were reviewed

with the patient and recommendation was made for cesarean section delivery. The risks and benefits of this surgery were reviewed, and knowing these facts, the patient gave informed consent.,PROCEDURE: , The patient was taken to the operating room where her epidural anesthesia was reinforced. She was prepped and draped in the usual fashion for the procedure. After adequate epidural level was confirmed, the scalp was utilized to make a transverse incision in the patient's lower abdominal wall. This incision was carried down to the level of the fascia, which was also transversely incised. After adequate hemostasis, the fascia was bluntly and sharply separated up from the underlying rectus muscle. The rectus muscle was separated in midline exposing the peritoneum. The peritoneum was carefully grasped and elevated with hemostats. It was entered in an up and down fashion with Metzenbaum scissors. The bladder blade was placed in the lower pole of the incision to protect the bladder.,The uterus was palpated and inspected. A thin lower uterine segment was noted. The vertex presentation was confirmed. The scalp was then utilized to make a transverse or Kerr incision in the lower uterine wall. Clear fluid was noted upon entering into the amniotic space. At 05:27, a term viable female infant was delivered up through the incision. She had spontaneous respirations. She was given bulb suctioning for clear fluid. Her cord was clamped and cut and she was delivered off the field to Dr. X who was attending. The baby girl was subsequently signed Apgars of 8 at one minute and 9 at five minutes. Her birth weight was found to be 5 pounds and 5 ounces.,The

placenta was manually extracted from the endometrial cavity. A ring clamp and two Allis clamps were placed around the margin of the uterine incision for hemostasis. The uterus was delivered up into the operative field. The endometrial cavity was swiped clean with a moist laparotomy pad. The uterine incision was then closed in a two-layered fashion with 0 Vicryl suture, the first layer interlocking and the second layer imbricating. Two additional stitches of 3-0 Vicryl suture were utilized for hemostasis. The uterine incision was noted to be hemostatic upon closure. The uterus was rotated forward, normal tubes and ovaries were noted on both sides. The uterus was then returned to its normal position of the abdominal cavity. The sponge and instrument count was performed for the first time at this point and found to be correct. The pelvis and anterior uterine space was then irrigated with saline solution. It was suctioned dry. A final check of the uterine incision confirmed hemostasis. The rectus muscle was stabilized across the midline with two simple stitches of 0 Vicryl suture. The subcutaneous tissue was then exposed, and the fascia closed with two running lengths of 0 Vicryl suture, beginning in lateral margins and overlapping the midline. The subcutaneous tissue was then irrigated and inspected. No active bleeding was noted. It was closed with a running length of 3-0 plain catgut suture. The skin was then approximated with surgical steel staples. The incision was infiltrated with a 0.5% solution of Marcaine local anesthetic. The incision was cleansed and sterilely dressed.,The patient was transferred to the recovery room in

stable condition. The estimated blood loss through the procedure was 450 mL. The sponge and instrument counts were performed two more times during closure and found to be correct each time.