PREOPERATIVE DIAGNOSES:,1. 36th and 4/7th week, intrauterine growth rate.,2. Charcot-Marie-Tooth disease.,3. Previous amniocentesis showing positive fetal lung maturity, family planning complete.,4. Previous spinal fusion.,5. Two previous C-sections. The patient refuses trial labor. The patient is with regular contractions dilated to 3, possibly an early labor, contractions are getting more and more painful.,POSTOPERATIVE DIAGNOSES:,1. 36th and 4/7th week, intrauterine growth rate.,2. Charcot-Marie-Tooth disease.,3. Previous amniocentesis showing positive fetal lung maturity, family planning complete.,4. Previous spinal effusion.,5. Two previous C-section. The patient refuses trial labor. The patient is with regular contractions dilated to 3, possibly an early labor, contractions are getting more and more painful.,6. Adhesions of bladder.,7. Poor fascia quality.,8. Delivery of a viable female neonate.,PROCEDURE PERFORMED:,1. A repeat low transverse cervical cesarean section.,2. Lysis of adhesions.,3. Dissection of the bladder of the anterior abdominal wall and away from the fascia.,4. The patient also underwent a bilateral tubal occlusion via Hulka clips.,COMPLICATIONS: , None.,BLOOD LOSS:, 600 cc.,HISTORY AND INDICATIONS: ,Indigo Carmine dye bladder test in which the bladder was filled, showed that there was no defects in the bladder of the uterus. The uterus appeared to be intact. This patient is a 26-year-old Caucasian female. The patient is well known to the OB/GYN clinic. The patient had two previous C-sections. She appears to be in probably early labor. She had an amniocentesis early today.

She is contracting regularly about every three minutes. The contractions are painful and getting much more so since the amniocentesis. The patient had fetal lung maturity noted. The patient also has probable IUGR as none of her babies have been over 4 lb. The patient's baby appears to be somewhat small. The patient suffers from Charcot-Marie-Tooth disease, which has left her wheelchair bound. The patient has had a spinal fusion, however, family planning is definitely complete per the patient. The patient refuses trial labor. The patient and I discussed the consent. She understands the foreseeable risks and complications, alternative treatment of the procedure itself, and recovery. Her questions were answered. The patient also understands that when we occlude her tube that she is at risk for failure of this part of the procedure, which would result in either an intrauterine or ectopic pregnancy. The patient understands this and would like to try our best.,PROCEDURE: ,The patient was taken back to the operative suite. She was given general anesthetic by Department of Anesthesiology. Once again, in layman's terms, the patient understands the risks. The patient had the informed consent reviewed and understood. The patient has had a Pfannenstiel incision, which was slightly bent towards the right side favoring the right side. The patient had the first knife went through this incision. The second knife was used to go to the level of fascia. The fascia was very thin, ruddy in appearance, and with abundant scar tissue. The fascia was incised. Following this, we were able to see the peritoneum. There was really no obvious rectus abdominal muscles noted.

They were very weak, atrophic, and thin. The patient has the peritoneum tented up. We entered the abdominal cavity. The bladder flap was then entered into the anterior abdominal wall and to the underlying area of the fascia. The bladder flap was then entered into the uterus as well. There are some bladder adhesions. We removed these adhesions and we removed the bladder of the fascia. We dissected the bladder of the lower segment. We made a small nick on the lower segment. We were able to utilize the blunt end of the knife to enter into the uterine cavity. The baby was in occiput transverse position with the ear being cocked at such a position as well. The patient's baby was delivered without difficulty. It was a 4 lb and 10 oz baby girl who vigorously cried well. There was a prolapse of the umbilical cord just below the chin as well and this may be attributed to the decelerations we caught on the monitor strip right before we decided to have her undergo resection. The patient's placenta was delivered. There was no retained placenta. The uterine incision was closed with two layers of #0 Vicryl, the second layer imbricating over the first. The patient on the right side had the inferior epigastric artery and the vein just underneath the peritoneum easily visualized. Then we ligated this as there was bleeding and oozing. The patient had the Indigo Carmine instilled into the bladder with some saline about 300 cc. The 400 cc was instilled. The bladder appears to be intact. The bladder did require extensive dissection of the fascia in order to be able to get a proper fascial edges for closure and dissection of the lower uterine segment. There was some oozing around the area of

the bladder. We placed an Avitene there. The two Hulka clips were placed perpendicular to going across each fallopian tube into the mesosalpinx. The patient has two clips on each side. There was excellent tubal occlusion and placement. The uterus was placed back into the abdominal cavity. We rechecked again. The tubal placement was excellent. It did not involve the round ligaments, uterosacral ligaments, the uteroovarian ligaments, and the tube into the mesosalpinx. The patient then underwent further examination. Hemostasis appeared to be good. The fascia was reapproximated with short running intervals of #0 Vicryl across the fascia. We took care not to get into any bleeders and to make sure that the fascia was indeed closed as best as it was possible. The Scarpa's fascia was reapproximated with #0 gut. The skin was reapproximated then as well via subcutaneous closure. The patient's sponge and needle counts found to be correct. Uterus appeared to be normal prior to closure. Bladder appeared to be normal. The patient's blood loss is 600 cc.