PREOPERATIVE DIAGNOSES:,1. Pregnancy at 38 weeks and three days.,2. Previous cesarean section x2.,3. Refusing trial of labor.,4. Multiparity, seeking family planning.,POSTOPERATIVE DIAGNOSES:,1. Pregnancy at 38 weeks and three days.,2. Previous cesarean section x2.,3. Refusing trial of labor.,4. Multiparity, seeking family planning.,5. Pelvic adhesions.,PROCEDURE PERFORMED:,1. Repeat low transverse cervical cesarean section with delivery of a viable female neonate.,2. Bilateral tubal ligation and partial salpingectomy.,3. Lysis of adhesions.,ANESTHESIA: , Spinal with Astramorph.,COMPLICATIONS: , None.,ESTIMATED BLOOD LOSS: , 800 cc.,FLUIDS: , 1800 cc of crystalloids.,URINE OUTPUT:, 600 cc of clear urine at the end of the procedure.,INDICATIONS: ,This is a 36-year-old African-American female gravida 4, para-2-0-1-2, who presents for elective repeat cesarean section. The patient has previous cesarean section x2 and refuses trial of labor. The patient also requests a tubal ligation for permanent sterilization and family planning.,FINDINGS:, A female infant in cephalic presentation in a ROP position. Apgars of 9 and 9 at one and five minutes respectively. Weight is 6 lb 2 oz and loose nuchal cord x1. Normal uterus, tubes, and ovaries.,PROCEDURE: ,After consent was obtained, the patient was taken to the operating room, where spinal anesthetic was found to be adequate. The patient was placed in the dorsal supine position with a leftward tilt and prepped and draped in the normal sterile fashion. The patient's

previous Pfannenstiel scar incision was removed and the incision was carried through the underlying layer of fascia using the second knife. The fascia was incised in the midline and the fascial incision was extended laterally using the second knife. The rectus muscles were separated in the midline. The peritoneum was identified, grasped with hemostats, and entered sharply with Metzenbaum scissors. This incision was extended superiorly and inferiorly with good visualization of the bladder. The bladder blade was then inserted and vesicouterine peritoneum was identified, grasped with an Allis clamp and entered sharply with Metzenbaum scissors. This incision was extended laterally and the bladder flap created digitally. The bladder blade was then reinserted and a small transverse incision was made along the lower uterine segment. This incision was extended laterally manually. The amniotic fluid was ruptured at this point with clear fluid obtained. The infant's head was delivered atraumatically. The nose and mouth were both suctioned on delivery. The cord was doubly clamped and cut. The infant was handed off to the awaiting pediatrician. Cord gases and cord bloods were obtained and sent. The placenta was then removed manually and the uterus exteriorized and cleared of all clots and debris. The uterine incision was reapproximated with #0 chromic in a running lock fashion. A second layer of the same suture was used with excellent hemostasis. Attention was now turned to the right fallopian tube, which was grasped with the Babcock and avascular space below the tube was entered using a hemostat. The tube was doubly

clamped using hemostat and the portion between the clamps was removed using Metzenbaum scissors. The ends of the tube were cauterized using the Bovie and they were then tied off with #2-0 Vicryl. Attention was then turned to the left fallopian tube, which was grasped with the Babcock and avascular space beneath the tube was entered using a hemostat. The tube was then doubly clamped with hemostat and the portion of tube between them was removed using the Metzenbaum scissors. The ends of the tubes were cauterized and the tube was suture-ligated with #2-0 Vicryl. There were some adhesions of the omentum to the bilateral adnexa. These were carefully taken down using Metzenbaum scissors with excellent hemostasis noted. The uterus was then returned to the abdomen and the bladder was cleared of all clots. The uterine incision was reexamined and found to be hemostatic. The fascia was then reapproximated with #0 Vicryl in a running fashion. Several interrupted sutures of #3-0 chromic were placed in the subcutaneous tissue. The skin was then closed with #4-0 undyed Vicryl in a subcuticular fashion. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct x2. The patient was taken to the recovery room in satisfactory condition. She will be followed immediately postoperatively within the hospital.