PREOPERATIVE DIAGNOSES:,1. Intrauterine pregnancy at 38 weeks.,2. Malpresentation.,POSTOPERATIVE DIAGNOSES:,1. Intrauterine pregnancy at 38 weeks.,2. Malpresentation.,3. Delivery of a viable male neonate.,PROCEDURE PERFORMED: , Primary low transverse cervical cesarean section.,ANESTHESIA: , Spinal with Astramorph.,ESTIMATED BLOOD LOSS: , 300 cc.,URINE OUTPUT:, 80 cc of clear urine.,FLUIDS: , 2000 cc of crystalloids.,COMPLICATIONS: , None.,FINDINGS: , A viable male neonate in the left occiput transverse position with Apgars of 9 and 9 at 1 and 5 minutes respectively, weighing 3030 g. No nuchal cord. No meconium. Normal uterus, fallopian tubes, and ovaries.,INDICATIONS: , This patient is a 21-year-old gravida 3, para 1-0-1-1 Caucasian female who presented to Labor and Delivery in labor. Her cervix did make some cervical chains. She did progress to 75% and -2, however, there was a raised lobular area palpated on the fetal head. However, on exam unable to delineate the facial structures, but definite fetal malpresentation. The fetal heart tones did start and it continued to have variable decelerations with contractions overall are reassuring. The contraction pattern was inadequate. It was discussed with the patient's family that in light of the physical exam and with the fetal malpresentation that a cesarean section will be recommended. All the questions were answered.,PROCEDURE IN DETAIL: , After informed consent was obtained in layman's terms, the patient was taken back to the operating suite and placed in the dorsal lithotomy position

with a leftward tilt. Prior to this, the spinal anesthesia was administered. The patient was then prepped and draped. A Pfannenstiel skin incision was made with the first scalpel and carried through to the underlying layer of fascia with the second scalpel. The fascia was then incised in the midline and extended laterally using Mayo scissors. The superior aspect of the rectus fascia was then grasped with Ochsners, tented up and the underlying layer of rectus muscle was dissected up bluntly as well as with Mayo scissors. The superior portion and inferior portion of the rectus fascia was identified, tented up and the underlying layer of rectus muscle was dissected up bluntly as well as with Mayo scissors. The rectus muscle was then separated in the midline. The peritoneum was then identified, tented up with hemostats and entered sharply with Metzenbaum scissors. The peritoneum was then gently stretched. The vesicouterine peritoneum was then identified, tented up with an Allis and the bladder flap was created bluntly as well as using Metzenbaum scissors. The uterus was entered with the second scalpel and large transverse incision. This was then extended in upward and lateral fashion bluntly. The infant was then delivered atraumatically. The nose and mouth were suctioned. The cord was then clamped and cut. The infant was handed off to the awaiting pediatrician. The placenta was then manually extracted. The uterus was exteriorized and cleared of all clots and debris. The uterine incision was then repaired using #0 chromic in a running fashion marking a U stitch. A second layer of the same suture was used in an imbricating fashion to obtain excellent

hemostasis. The uterus was then returned to the anatomical position. The abdomen and the gutters were cleared of all clots. Again, the incision was found to be hemostatic. The rectus muscle was then reapproximated with #2-0 Vicryl in a single interrupted stitch. The rectus fascia was then repaired with #0 Vicryl in a running fashion locking the first stitch and first last stitch in a lateral to medial fashion. This was palpated and the patient was found to be without defect and intact. The skin was then closed with staples. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct x2. She will be followed up as an inpatient with Dr. X.