PREOPERATIVE DIAGNOSES:,1. Intrauterine pregnancy at 37 plus weeks, nonreassuring fetal heart rate.,2. Protein S low.,3. Oligohydramnios.,POSTOPERATIVE:,1. Intrauterine pregnancy at 37 plus weeks, nonreassuring fetal heart rate.,2. Protein S low.,3. Oligohydramnios.,4. Delivery of a viable female, weight 5 pound, 14 ounces. Apgars of 9 and 9 at 1 and 5 minutes respectively and cord pH is 7.314.,OPERATION PERFORMED:, Low transverse C-section.,ESTIMATED BLOOD LOSS: , 500 mL.,DRAINS: , Foley.,ANESTHESIA: , Spinal with Duramorph.,HISTORY OF PRESENT ILLNESS: ,This is a 21-year-old white female gravida 1, para 0, who had presented to the hospital at 37-3/7 weeks for induction. The patient had oligohydramnios and also when placed on the monitor had nonreassuring fetal heart rate with late deceleration. Due to the IUGR as well a decision for a C-section was made.,PROCEDURE: , The patient was taken to the operating room and placed in a seated position with standard spinal form of anesthesia administered by the Anesthesia Department. The patient was then repositioned, prepped and draped in a slight left lateral tilt. Once this was completed first knife was used to make a low transverse skin incision approximately two fingerbreadths above the pubic symphysis. This was extended down to the level of the fascia. The fascia was nicked in the center and extended in transverse fashion. Edges of the fascia were grasped with Kocher and both blunt and sharp dissection both caudally and cephalic was completed consistent with the Pfannenstiel technique. The abdominal rectus muscle was

divided in the center, extended in vertical fashion and the peritoneum was entered at a high point and extended in vertical fashion. Bladder blade was put in place and a bladder flap was created with the use of Metzenbaum and pickups and then bluntly dissected via cautery and reincorporated in the bladder blade. Second knife was used to make a low transverse uterine incision with care being taken to avoid the presenting part of fetus. Presenting part was vertex, the head was delivered, followed by the remaining portion of the body. The mouth and nose were suctioned through bulb syringe and the cord was doubly clamped and cut and then the newborn handed off to waiting nursing personnel. Cord pH blood and cord blood was obtained. The placenta was delivered manually and the uterus was externalized and the lining was cleaned off any remaining placental fragments and blood and the incisional edges were reapproximated with 0-chromic and a continuous locking stitch with a second layer used to imbricate the first. The bladder flap was re-peritonized with Gelfoam underneath and abdomen was irrigated with copious amounts of saline and the uterus was placed back in its anatomical position. The gutters were wiped clean of any remaining blood and fluid and the edges of the perineum grasped with hemostats and continuous locking stitches of 2-0 Vicryl was used to reapproximate the abdominal rectus muscle as well as the perineum. This area was then irrigated. Cautery was used for adequate hemostasis, corners of the fascia grasped with hemostats and continuous locking stitch of 1-Vicryl was started at both corners and overlapped in the

center. Subcutaneous tissue was irrigated with saline and reapproximated with 3-0 Vicryl. Skin edges reapproximated with sterile staples. Sterile dressing was applied. The uterus was evacuated of any remaining clots vaginally. The patient was taken to recovery room in stable condition. Instrument count, needle count, and sponge counts were all correct.