PREOPERATIVE DIAGNOSES:,1. Intrauterine pregnancy at 33 weeks, twin gestation.,2. Active preterm labor.,3. Advanced dilation.,4. Multiparity.,5. Requested sterilization.,POSTOPERATIVE DIAGNOSIS:,1. Intrauterine pregnancy at 33 weeks, twin gestation.,2. Active preterm labor.,3. Advanced dilation.,4. Multiparity.,5. Requested sterilization.,6. Delivery of a viable female A weighing 4 pounds 7 ounces, Apgars were 8 and 9 at 1 and 5 minutes respectively and female B weighing 4 pounds 9 ounces, Apgars 6 and 7 at 1 and 5 minutes respectively.,7. Uterine adhesions and omentum adhesions.,OPERATION PERFORMED: , Repeat low-transverse C-section, lysis of omental adhesions, lysis of uterine adhesions with repair of uterine defect, and bilateral tubal ligation.,ANESTHESIA: , General.,ESTIMATED BLOOD LOSS: , 500 mL.,DRAINS:, Foley.,This is a 25-year-old white female gravida 3, para 2-0-0-2 with twin gestation at 33 weeks and previous C-section. The patient presents to Labor and Delivery in active preterm labor and dilated approximately 4 to 6 cm. The decision for C-section was made.,PROCEDURE:, The patient was taken to the operating room and placed in a supine position with a slight left lateral tilt and she was then prepped and draped in usual fashion for a low transverse incision. The patient was then given general anesthesia and once this was completed, first knife was used to make a low transverse incision extending down to the level of the fascia. The fascia was nicked in the center and extended in a transverse fashion with the use of curved Mayo scissors. The edges of the fascia

were grasped with Kocher and both blunt and sharp dissection was then completed both caudally and cephalically. The abdominal rectus muscle was divided in the center and extended in a vertical fashion. Peritoneum was entered at a high point and extended in a vertical fashion as well. The bladder blade was put in place. The bladder flap was created with the use of Metzenbaum scissors and dissected away caudally. The second knife was used to make a low transverse incision with care being taken to avoid the presenting part of the fetus. The first fetus was vertex. The fluid was clear. The head was delivered followed by the remaining portion of the body. The cord was doubly clamped and cut. The newborn handed off to waiting pediatrician and nursery personnel. The second fluid was ruptured. It was the clear fluid as well. The presenting part was brought down to be vertex. The head was delivered followed by the rest of the body and the cord was doubly clamped and cut, and newborn handed off to waiting pediatrician in addition of the nursery personnel. Cord pH blood and cord blood was obtained from both of the cords with careful identification of A and B. Once this was completed, the placenta was delivered and handed off for further inspection by Pathology. At this time, it was noted at the uterus was adhered to the abdominal wall by approximately of 3 cm x 3 cm thick uterine adhesion and this was needed to be released by sharp dissection. Then, there were multiple omental adhesions on the surface of the uterus itself. This needed to be released as well as on the abdominal wall and then the uterus could be externalized. The lining was

wiped clean of any remaining blood and placental fragments and the edges of the uterus were grasped in four quadrants with Kocher and continuous locking stitch of 0 chromic was used to re-approximate the uterine incision, with the second layer used to imbricate the first. The bladder flap was re-approximated with 3-0 Vicryl and Gelfoam underneath. The right fallopian tube was grasped with a Babcock, it was doubly tied off with 0 chromic and the knuckle portion was then sharply incised and cauterized. The same technique was completed on the left side with the knuckle portion cut off and cauterized as well. The defect on the uterine surface was reinforced with 0 Vicryl in a baseball stitch to create adequate Hemostasis. Interceed was placed over this area as well. The abdominal cavity 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. The edges of the peritoneum were grasped with hemostats and a continuous locking stitch was used to re-approximate abdominal rectus muscles as well as the peritoneal edges. The abdominal rectus muscle was irrigated. The corners of the fascia grasped with hemostats and continuous locking stitch of 0 Vicryl started on both corners and overlapped on the center. The subcutaneous tissue was irrigated. Cautery was used to create adequate hemostasis and 3-0 Vicryl was used to re-approximate the subcutaneous tissue. Skin edges were re-approximated with sterile staples. Sterile dressing was applied. Uterus was evacuated of any remaining blood vaginally. The patient was taken to the recovery room in

stable condition. Instrument count, needle count, and sponge counts were all correct.