PREOPERATIVE DIAGNOSES:,1. Term pregnancy.,2. Desires permanent sterilization.,POSTOPERATIVE DIAGNOSES:,1. Term pregnancy.,2. Desires permanent sterilization.,PROCEDURE:,1. Repeat low-transverse cesarean section.,2. Bilateral tubal ligation.,3. Extensive anterior abdominal wall/uterine/bladder adhesiolysis.,ANESTHESIA:, Spinal/epidural with good effect.,FINDINGS: ,Delivered vigorous male infant from cephalic presentation. Apgars 9/9. Birth weight 6 pounds 14 ounces. Infant suctioned with a bulb upon delivery of the head and body. Cord clamped and cut and infant passed to pediatric team present. Complete placenta manually extracted intact with three vessel cord. Extensive anterior abdominal wall adhesions with the anterior abdominal wall completely adhered to the anterior uterus throughout its entire length of the incision. In addition, the bladder was involved in adhesion mass complex. A window was developed surgically at the apical aspect of the incision enabling finger to pass to get behind the dense anterior abdominal wall adhesions. These adhesions were surgically transected using Bovie cautery technique freeing up the anterior uterine attachment from the anterior abdominal wall. Upon initial entry through the fibrous layer of the anterior abdominal wall _____ into the serosal and slightly muscular part of the anterior uterus due to the dense adhesion attachment that had occurred from previous surgeries. Bilateral tubal ligation performed without difficulty via Parkland technique.,ESTIMATED BLOOD LOSS: , 500 mL.,COMPLICATIONS: , None.,URINE OUTPUT: ,Per

anesthesia records. Urine cleared postoperatively.,IV FLUIDS: ,Per anesthesia records.,The patient tolerated the procedure well and was taken to the recovery room in stable condition with stable vital signs.,OPERATIVE TECHNIQUE: , The patient was placed in a supine position after spinal/epidural anesthesia. She was prepped and draped in the usual manner for repeat cesarean section. A sharp knife was used to make a Pfannenstiel skin incision at the site of the previous scar. This was carried through the subcutaneous tissue into the dense fibromuscular and fascial layer with a sharp knife. This incision was extended laterally with Mayo scissors. Dense fibromuscular layer was encountered from the patient's previous surgeries. Upon entry, incision was entered into the serosal and partial muscular layer of the anterior uterus and there was no free area to enter into the peritoneal cavity due to dense fibromuscular adhesions of the entire uterus to the anterior abdominal wall at the length of the incision. Fascia was previously separated superiorly and inferiorly from the muscular layer. A surgical window was created at the apical aspect of the incision in the direction of the uterine fundus. Finger was able to be passed and placed behind the dense adhesions between the uterus through anterior abdominal wall. This adhesion complex was transacted via Bovie cautery its entire length circumferentially freeing the uterus from its attachment to anterior abdominal wall. Inferiorly, difficulty was encountered with adhesion separation involving the bladder additionally to the uterus and the anterior abdominal wall. These adhesions likewise were

surgically transacted via sharp, blunt, and electrocautery dissection. This was successfully done without anterior entry into the bladder. Smooth pickups and Metzenbaum scissors were then used to do sharp dissection to separated the bladder from its attachment to the lower uterine segment enabling the vesicouterine peritoneal reflection for incision of the uterus. The uterus was then incised using a sharp knife and low transverse incision. This was extended with bandage scissors. The infant was delivered easily from a cephalic presentation. Bulb suction was done following delivery of the head and body. The cord clamped and cut and the infant passed to pediatric team present. Cord segment and cord blood was obtained. Complete placenta manually extracted intact with three vessel cord. Vigorous male infant, Apgars 9/9, weight 6 pounds 14 ounces. Complete placenta with three vessels retrieved. Uterus was exteriorized from the abdominal cavity. Wet lap applied to the fundus and dry lap used to remove the remaining membranous tissue from the lining. Pennington clamps placed at the uterine incision angles and the inferior incision lip. A #1 chromic suture closed the uterus in running continuous interlocking closure. Good hemostasis upon completion of the closure. Laparotomy pads placed in the posterior cul-de-sac to remove any blood or clots. The uterus was returned to the abdominal cavity, after using #1 chromic suture to close the anterior uterine incision, that was partial thickness through the serosal end of the muscular layer at midline adhesion. This was closed with chromic suture in a running continuous interlocking closure

with good hemostasis. Attention was then focused on the bilateral tubal ligation. Babcock clamp placed in the mid fallopian tube and elevated. Cautery was used to make a window in the avascular segment of the mesosalpinx. Proximal and distal #1 chromic suture ligation with mid fallopian tube transection performed. The ligated proximal and distal stumps were then cauterized with Bovie cautery. This tubal ligation procedure was done in a bilateral fashion. Upon completion of tubal ligation, uterus was returned to the abdominal cavity. Left and right gutters examined and found to be clean and dry. Evaluation of the low uterine segment incision revealed continued hemostasis. Oozing was encountered in the inferior bladder of dissection and 2-0 chromic suture in running continuous fashion, partial thickness of the bladder to control the oozing at this site was successfully done. Interceed was then placed on the low uterine incision and the low anterior uterine aspect. The midline rectus including peritoneum was re-approximated with simple interrupted chromic sutures. Irrigation of the muscular layer with good hemostasis noted. The fascia was closed with #1 Vicryl in a running continuous closure. Subcutaneous tissue was irrigated, additional hemostasis with Bovie cautery. The skin was closed with staples.