PREOPERATIVE DIAGNOSES:,1. Pregnancy at 40 weeks.,2. Failure to progress.,3. Premature prolonged rupture of membranes.,4. Group B strep colonization.,POSTOPERATIVE DIAGNOSIS:,1. Pregnancy at 40 weeks.,2. Failure to progress.,3. Premature prolonged rupture of membranes.,4. Group B strep colonization.,5. Delivery of viable male neonate.,PROCEDURE PERFORMED: , Primary low transverse cesarean section via Pfannenstiel incision.,ANESTHESIA: ,Spinal.,ESTIMATED BLOOD LOSS: , 1000 cc.,FLUID REPLACEMENT: , 2700 cc crystalloid.,URINE:, 500 cc clear yellow urine in the Foley catheter.,INTRAOPERATIVE FINDINGS: ,Normal appearing uterus, tubes, and ovaries. A viable male neonate with Apgars of 9 and 9 at 1 and 5 minutes respectively. Infant weight equaled to 4140 gm with clear amniotic fluid. The umbilical cord was wrapped around the leg tightly x1. Infant was in a vertex, right occiput anterior position.,INDICATIONS FOR PROCEDURE: ,The patient is a 19-year-old G1 P0 at 41 and 1/7th weeks' intrauterine pregnancy. She presented at mid night on 08/22/03 complaining of spontaneous rupture of membranes, which was confirmed in Labor and Delivery. The patient had a positive group beta strep colonization culture and was started on penicillin. The patient was also started on Pitocin protocol at that time. The patient was monitored throughout the morning showing some irregular contractions every 5 to 6 minutes and then eventually no contractions on the monitor. IUPC was placed without difficulty and contractions appeared to be regular, however, they were

inadequate amount of the daily units. The patient was given a rest from the Pitocin. She walked and had a short shower. The patient was then placed back on Pitocin with IUPC in place and we were unable to achieve adequate contractions. Maximum cervical dilation was 5 cm, 80% effaced, negative 2 station, and cephalic position. At the time of C-section, the patient had been ruptured for over 24 hours and it was determined that she would not progress in her cervical dilation, as there was suspected macrosomia on ultrasound. Options were discussed with the patient and family and it was determined that we will take her for C-section today. Consent was signed. All questions were answered with Dr. X present.,PROCEDURE: , The patient was taken to the operative suite where a spinal anesthetic was placed. She was placed in the dorsal supine position with left upward tilt. She was prepped and draped in the normal sterile fashion and her spinal anesthetic was found to adequate. A Pfannenstiel incision was made with a first scalpel and carried through the underlying layer of fascia with a second scalpel. The fascia was incised in the midline and extended laterally using curved Mayo scissors. The superior aspect of the fascial incision was grasped with Ochsner and Kocher clamps and elevated off the rectus muscles. Attention was then turned to the inferior aspect of the incision where Kocher clamps were used to elevate the fascia off the underlying rectus muscle. The rectus muscle was separated in the midline bluntly. The underlying peritoneum was tented up with Allis clamps and incised using Metzenbaum scissors. The peritoneum was then bluntly

stretched. The bladder blade was placed. The vesicouterine peritoneum was identified, tented up with Allis' and entered sharply with Metzenbaum scissors. The incision was extended laterally and the bladder flap created digitally. The bladder blade was then reinserted in the lower uterine segment. A low transverse uterine incision was made with a second scalpel. The uterine incision was extended laterally bluntly. The bladder blade was removed and the infant's head was delivered with the assistance of a vacuum. Infant's nose and mouth were bulb suctioned and the body was delivered atraumatically. There was, of note, an umbilical cord around the leg tightly x1.,Cord was clamped and cut. Infant was handed to the waiting pediatrician. Cord gas was sent for pH as well as blood typing. The placenta was manually removed and the uterus was exteriorized and cleared of all clots and debris. The uterine incision was grasped circumferentially with Alfred clamps and closed with #0-Chromic in a running locked fashion. A second layer of imbricating stitch was performed using #0-Chromic suture to obtain excellent hemostasis. The uterus was returned to the abdomen. The gutters were cleared of all clots and debris. The rectus muscle was loosely approximated with #0-Vicryl suture in a single interrupted fashion. The fascia was reapproximated with #0-Vicryl suture in a running fashion. The subcutaneous Scarpa's fascia was then closed with #2-0 plain gut. The skin was then closed with staples. The incision was dressed with sterile dressing and bandage. Blood clots were evacuated from the vagina. The patient tolerated the procedure well. The sponge, lap, and

needle counts were correct x2. The mother was taken to the recovery room in stable and satisfactory condition.