PREOPERATIVE DIAGNOSES,1. A 40 weeks 6 days intrauterine pregnancy.,2. History of positive serology for HSV with no evidence of active lesions.,3. Non-reassuring fetal heart tones.,POST OPERATIVE DIAGNOSES,1. A 40 weeks 6 days intrauterine pregnancy.,2. History of positive serology for HSV with no evidence of active lesions.,3. Non-reassuring fetal heart tones.,PROCEDURES,1. Vacuum-assisted vaginal delivery of a third-degree midline laceration and right vaginal side wall laceration.,2. Repair of the third-degree midline laceration lasting for 25 minutes.,ANESTHESIA: , Local.,ESTIMATED BLOOD LOSS: , 300 mL.,COMPLICATIONS: ,None.,FINDINGS,1. Live male infant with Apgars of 9 and 9.,2. Placenta delivered spontaneously intact with a three-vessel cord.,DISPOSITION: ,The patient and baby remain in the LDR in stable condition.,SUMMARY: , This is a 36-year-old G1 woman who was pregnant since 40 weeks 6 days when she was admitted for induction of labor for post dates with favorable cervix. When she was admitted, her cervix was 2.5 cm dilated with 80% effacement. The baby had a -2 station. She had no regular contractions. Fetal heart tones were 120s and reactive. She was started on Pitocin for labor induction and labored quite rapidly. She had spontaneous rupture of membranes with a clear fluid. She had planned on an epidural; however, she had sudden rapid cervical change and was unable to get the epidural. With the rapid cervical change and descent of fetal head, there were some variable decelerations. The baby was at a +1 station when the patient began pushing. I had her push to get the

baby to a +2 station. During pushing, the fetal heart tones were in the 80s and did not recover in between contractions. Because of this, I recommended a vacuum delivery for the baby. The patient agreed.,The baby's head was confirmed to be in the right occiput anterior presentation. The perineum was injected with 1% lidocaine. The bladder was drained. The vacuum was placed and the correct placement in front of the posterior fontanelle was confirmed digitally. With the patient's next contraction, the vacuum was inflated and a gentle downward pressure was used to assist with brining the baby's head to a +3 station. The contraction ended. The vacuum was released and the fetal heart tones remained in the, at this time, 90s to 100s. With the patient's next contraction, the vacuum was reapplied and the baby's head was delivered to a +4 station. A modified Ritgen maneuver was used to stabilize the fetal head. The vacuum was deflated and removed. The baby's head then delivered atraumatically. There was no nuchal cord. The baby's anterior shoulder delivered after a less than 30 second delay. No additional maneuvers were required to deliver the anterior shoulder. The posterior shoulder and remainder of the body delivered easily. The baby's mouth and nose were bulb suctioned. The cord was clamped x2 and cut. The infant was handed to the respiratory therapist.,Pitocin was added to the patient's IV fluids. The placenta delivered spontaneously, was intact and had a three-vessel cord. A vaginal inspection revealed a third-degree midline laceration as well as a right vaginal side wall laceration. The right side wall laceration was repaired

with #3-0 Vicryl suture in a running fashion with local anesthesia. The third-degree laceration was also repaired with #3-0 Vicryl sutures. Local anesthesia was used. The capsule was visible, but did not appear to be injured at all. It was reinforced with three separate interrupted sutures and then the remainder of the incision was closed with #3-0 Vicryl in the typical fashion.,The patient tolerated the procedure very well. She remains in the LDR with the baby. The baby is vigorous, crying and moving all extremities. He will go to the new born nursery when ready. The total time for repair of the laceration was 25 minutes.