

PREOPERATIVE DIAGNOSES, 1. Intrauterine pregnancy at 35-1/7., 2. Rh isoimmunization., 3. Suspected fetal anemia., 4. Desires permanent sterilization., POSTOPERATIVE DIAGNOSES, 1. Intrauterine pregnancy at 35-1/7., 2. Rh isoimmunization., 3. Suspected fetal anemia., 4. Desires permanent sterilization., OPERATION PERFORMED: , Primary low transverse cesarean section by Pfannenstiel skin incision with bilateral tubal sterilization., ANESTHESIA: , Spinal anesthesia., COMPLICATIONS: , None., ESTIMATED BLOOD LOSS: , 500 mL., INTRAOPERATIVE FLUIDS: , 1000 mL crystalloids., URINE OUTPUT: , 300 mL clear urine at the end of procedure., SPECIMENS: , Cord gases, hematocrit on cord blood, placenta, and bilateral tubal segments., INTRAOPERATIVE FINDINGS: , Male infant, vertex position, very bright yellow amniotic fluid. Apgars 7 and 8 at 1 and 5 minutes respectively. Weight pending at this time. His name is Kasson as well as umbilical cord and placenta stained yellow. Otherwise normal appearing uterus and bilateral tubes and ovaries., DESCRIPTION OF OPERATION: , After informed consent was obtained, the patient was taken to the operating room where spinal anesthesia was obtained by Dr. X without difficulties. The patient was placed in supine position with leftward tilt. Fetal heart tones were checked and were 140s, and she was prepped and draped in a normal sterile fashion. At this time, a Pfannenstiel skin incision made with a scalpel and carried down to the underlying fascia with electrocautery. The fascia was nicked sharply in the midline. The fascial incision was extended laterally with Mayo

scissors. The inferior aspect of the fascial incision was grasped with Kocher x2, elevated, and rectus muscles dissected sharply with the use of Mayo scissors. Attention was then turned to the superior aspect of the fascial incision. Fascia was grasped, elevated, and rectus muscles dissected off sharply. The rectus muscles were separated in the midline bluntly. The peritoneum was identified, grasped, and entered sharply and the peritoneal incision extended inferiorly and superiorly with good visualization of bladder. Bladder blade was inserted. Vesicouterine peritoneum was tented up and a bladder flap was created using Metzenbaum scissors. Bladder blade was reinserted to effectively protect the bladder from the operative field and the lower uterine segment incised in a transverse U-shaped fashion with the scalpel. Uterine incision was extended laterally and manually. Membranes were ruptured and bright yellow clear amniotic fluid was noted. Infant's head was in a floating position, able to flex the head, push against the incision, and then easily brought it to the field vertex. Nares and mouth were suctioned with bulb suction. Remainder of the infant was delivered atraumatically. The infant was very pale upon delivery. Cord was doubly clamped and cut and immediately handed to the awaiting intensive care nursery team. An 8 cm segment of the tube was doubly clamped and transected. Cord gases were obtained. Cord was then cleansed, laid on a clean laparotomy sponge, and cord blood was drawn for hematocrit measurements. At this time, it was noted that the cord was significantly yellow stained as well as the placenta. At this time, the placenta was

delivered via gentle traction on the cord and exterior uterine massage. Uterus was exteriorized and cleared off all clots and debris with dry laparotomy sponge and the lower uterine segment was closed with 1-0 chromic in a running locked fashion. Two areas of oozing were noted and separate figure-of-eight sutures were placed to obtain hemostasis. At this time, the uterine incision was hemostatic. The bladder was examined and found to be well below the level of the incision repair. Tubes and ovaries were examined and found to be normal. The patient was again asked if she desires permanent sterilization of which she agrees and therefore the right fallopian tube was identified and followed out to the fimbriated end and grasped at the mid portion with a Babcock clamp. Mesosalpinx was divided with electrocautery and a 4-cm segment of tube was doubly tied and transected with a 3-cm segment of tube removed. Hemostasis was noted. Then, attention was turned to the left fallopian tube which in similar fashion was grasped and brought out through the fimbriated end and grasped the midline portion with Babcock clamp. Mesosalpinx was incised and 3-4 cm tube doubly tied, transected, and excised and excellent hemostasis was noted. Attention was returned to the uterine incision which is seemed to be hemostatic and uterus was returned to the abdomen. Gutters were cleared off all clots and debris. Lower uterine segments were again re-inspected and found to be hemostatic. Sites of tubal sterilization were also visualized and were hemostatic. At this time, the peritoneum was grasped with Kelly clamps x3 and closed with running 3-0

Vicryl suture. Copious irrigation was used. Rectus muscle belly was examined and found to be hemostatic and tacked and well approximated in the midline. At this time, the fascia was closed using 0 Vicryl in a running fashion. Manual palpation confirms thorough and adequate closure of the fascial layer. Copious irrigation was again used. Hemostasis noted, and skin was closed with staples. The patient tolerated the procedure well. Sponge, lap, needle, and instrument counts were correct x3 and the patient was sent to the recovery room awake and stable condition. Infant assumed the care of the intensive care nursery team and being followed and workup up for isoimmunization and fetal anemia. The patient will be followed for her severe right upper quadrant pain post delivery. If she continues to have pain, may need a surgical consult for gallbladder and/or angiogram for evaluation of right kidney and questionable venous plexus. This all will be relayed to Dr. Y, her primary obstetrician who was on call starting this morning at 7 a.m. through the weekend.