PREOPERATIVE DIAGNOSES:,1. Intrauterine pregnancy at 39 and 1/7th weeks.,2. Previous cesarean section, refuses trial of labor.,3. Fibroid uterus.,4. Oligohydramnios.,5. Nonreassuring fetal heart tones.,POSTOPERATIVE DIAGNOSES:,1. Intrauterine pregnancy at 39 and 1/7th weeks.,2. Previous cesarean section, refuses trial of labor.,3. Fibroid uterus.,4. Oligohydramnios.,5. Nonreassuring fetal heart tones.,PROCEDURE PERFORMED:, Repeat low-transverse cesarean section via Pfannenstiel incision.,ANESTHESIA:, General.,COMPLICATIONS:, None.,ESTIMATED BLOOD LOSS:, 1200 cc.,FLUIDS:, 2700 cc.,URINE:, 400 cc clear at the end of the procedure.,DRAINS: , Foley catheter.,SPECIMENS: ,Placenta, cord gases and cord blood.,INDICATIONS: ,The patient is a G5 P1 Caucasian female at 39 and 1/7th weeks with a history of previous cesarean section for failure to progress and is scheduled cesarean section for later this day who presents to ABCD Hospital complaining of contractions. She was found to not be in labor, but had nonreassuring heart tones with a subtle late decelerations and AFOF of approximately 40 mm. A decision was made to take her for a C-section early.,FINDINGS: , The patient had an enlarged fibroid uterus with a large anterior fibroid with large varicosities, normal appearing tubes and ovaries bilaterally. There was a live male infant in the ROA position with Apgars of 9 at 1 minute and 9 at 5 minutes and a weight of 5 lb 4 oz.,PROCEDURE: , Prior to the procedure, an informed consent was obtained. The patient who previously been

interested in a tubal ligation refused the tubal ligation prior to surgery. She states that she and her husband are fully disgusted and that they changed their mind and they were adamant about this. After informed consent was obtained, the patient was taken to the operating room where spinal anesthetic with Astramorph was administered. She was then prepped and draped in the normal sterile fashion. Once the anesthetic was tested, it was found to be inadequate and a general anesthetic was administered. Once the general anesthetic was administered and the patient was asleep, the previous incision was removed with the skin knife and this incision was then carried through an underlying layer of fascia with a second knife. The fascia was incised in the midline with a second knife. This incision was then extended laterally in both directions with the Mayo scissors. The superior aspect of this fascial incision was then dissected off to the underlying rectus muscle bluntly without using Ochsner clamps. It was then dissected in the midline with Mayo scissors. The inferior aspect of this incision was then addressed in a similar manner. The rectus muscles were then separated in the midline with a hemostat. The rectus muscles were separated further in the midline with Mayo scissors superiorly and inferiorly. Next, the peritoneum was grasped with two hemostats, tented up and entered sharply with the Metzenbaum scissors. This incision was extended inferiorly with the Metzenbaum scissors, being careful to avoid the bladder and the peritoneal incision was extended bluntly. Next, the bladder blade was placed. The vesicouterine

peritoneum was identified, tenting up with Allis clamps and entered sharply with the Metzenbaum scissors. This incision was extended laterally in both directions and a bladder flap was created digitally. The bladder blade was then reinserted. Next, the uterine incision was made with a second knife and the uterus was entered with the blunt end of the knife. Next, the uterine incision was extended laterally in both directions with the banded scissors. Next, the infant's head and body were delivered without difficulty. There was multiple section on the abdomen. The cord was clamped and cut. Section of cord was collected for gases and the cord blood was collected. Next, the placenta was manually extracted. The uterus was exteriorized and cleared of all clots and debris. The edges of the uterine incision were then identified with Allis _____ clamps. The uterine incision was reapproximated with #0 chromic in a running locked fashion and a second layer of the same suture was used to obtain excellent hemostasis. One figure-of-eight with #0 chromic was used in one area to prevent a questionable hematoma from expanding along the varicosity for the anterior fibroid. After several minutes of observation, the hematoma was seem to be non-expanding. The uterus was replaced in the abdomen. The uterine incision was reexamined and seem to be continuing to be hemostatic. The pelvic gutters were then cleared of all clots and debris. The vesicouterine peritoneum was then reapproximated with #3-0 Vicryl in a running fashion. The peritoneum was then closed with #0 Vicryl in a running fashion. The rectus muscles reapproximated with #0

Vicryl in a single interrupted stitch. The fascia was closed with #0 Vicryl in a running locked fashion and the skin was closed with staples. The patient tolerated the procedure well. Sponge, lap, and needle counts were correct x3. The patient was then taken to Recovery in stable condition and she will be followed for immediate postoperative course in the hospital.