HISTORY: , This patient with prenatal care in my office who did have some preterm labor and was treated with nifedipine and was stable on nifedipine and bed rest; unfortunately, felt decreased fetal movement yesterday, 12/29/08, presented to the hospital for evaluation on the evening of 12/29/08. At approximately 2030 hours and on admission, no cardiac activity was noted by my on-call partner, Dr. X. This was confirmed by Dr. Y with ultrasound and the patient was admitted with a diagnosis of intrauterine fetal demise at 36 weeks' gestation.,SUMMARY:, She was admitted. She was 3 cm dilated on admission. She desired induction of labor. Therefore, Pitocin was started. Epidural was placed for labor pain. She did have a temperature of 100.7 and antibiotics were ordered including gentamicin and clindamycin secondary to penicillin allergy. She remained febrile, approximately 100.3. She then progressed. On my initial exam at approximately 0730 hours, she was 3 to 4 cm dilated. She had reported previously some mucous discharge with no ruptured membranes. Upon my exam, no membranes were noted. Attempted artificial rupture of membranes was performed. No fluid noted and there was no fluid discharge noted all the way until the time of delivery. Intrauterine pressure catheter was placed at that time to document there are adequate pressures on contraction secondary to induction of labor. She progressed well and completely dilated, pushed approximately three times, and proceeded with delivery.,DELIVERY NOTE:, Delivery is a normal spontaneous vaginal delivery of an intrauterine fetal demise.

Fetal position is right occiput anterior.,COMPLICATIONS: , Again, intrauterine fetal demise. Placenta delivery spontaneous. Condition was intact with a three-vessel cord. Lacerations; she had a small right periurethral laceration as well as a small second-degree midline laceration. These were both repaired postdelivery with 4-0 Vicryl on an SH and a 3-0 Vicryl on a CT-1 respectively. Estimated blood loss was 200 mL.,Infant is a male infant, appears grossly morphologically normal. Apgars were 0 and 0. Weight pending at this time.,NARRATIVE OF DELIVERY:, I was called. This patient was completely dilated. I arrived. She pushed for three contractions. She was very comfortable. She delivered the fetal vertex in the right occiput anterior position followed by the remainder of the infant. There was a tight nuchal cord x1 that was reduced after delivery of the fetus. Cord was doubly clamped. The infant was transferred to a bassinet cleaned by the nursing staff en route. The placenta delivered spontaneously, was carefully examined, found to be intact. No signs of abruption. No signs of abnormal placentation or abnormal cord insertion. The cord was examined and a three-vessel cord was confirmed. At this time, IV Pitocin and bimanual massage. Fundus firm as above with minimal postpartum bleeding. The vagina and perineum were carefully inspected. A small right periurethral laceration was noted, was repaired with a 4-0 Vicryl on an SH needle followed by a small second-degree midline laceration, was repaired in a normal running fashion with a 3-0 Vicryl suture. At this time, the repair is intact. She is hemostatic. All instruments and sponges were

removed from the vagina and the procedure was ended.,Father of the baby has seen the baby at this time and the mother is waiting to hold the baby at this time. We have called pastor in to baptize the baby as well as calling social work. They are deciding on a burial versus cremation, have decided against autopsy at this time. She will be transferred to postpartum for her recovery. She will be continued on antibiotics secondary to fever to eliminate endometritis and hopefully will be discharged home tomorrow morning.,All of the care and findings were discussed in detail with Christine and Bryan and at this time obviously they are very upset and grieving, but grieving appropriately and understanding the findings and the fact that there is not always a known cause for a term fetal demise. I have discussed with her that we will do some blood workup postdelivery for infectious disease profile and clotting disorders.