NORMAL SPONTANEOUS VAGINAL DELIVERY

Date of Procedure:
Preop Dx: 38 week IUP in active labor (with-list any other diagnosis).
Postop DX: Same with delivery of viable male infant at 1400 hours weighing 7#12oz with Apgars of 9 @ 1 min and 9 @ 5 min.
Procedure: Spontaneous Vaginal Delivery
Surgeon: (list staff physician name)
Assistants: Junior Resident and Senior Resident
Anesthesia: Local infiltration of _____/pudendal infiltration of _____/epidural
EBL:
Indications: This 19 y/o G1P0 presents at 39 4/7 weeks gestation by LMP with an EDC of 04/06/12, c/o regular uterine contractions. Her prenatal course was complicated by ___. Prenatal lab data includes blood type O+ with a negative Ab screen, Rubella Immune, VDRL NR, HepBsAg neg, HIV NR, GBS neg. She presented at 0400 hours this am complaining of UCs q 5 minutes. At that time, her cervix was 2 cm, 90% effaced and at a –1 station. FHR was reactive and reassuring. She remained normotensive throughout the course of her labor. Slow progress was made initially, and at 0800 hours artificial rupture of membranes was performed with a return of clear fluid. At that time, her cervix was 5cm, 100% effaced and the fetal vertex was at a 0 station. An epidural was placed for analgesia at this time. She progressed to complete by 1200 hours and was allowed to push, bringing the infant's vertex to the perineum.
Procedure: The patient was noted to be complete and pushing, so was placed in the dorsal lithotomy position, prepped and draped in the usual sterile fashion for a vaginal delivery. (Pt. Noted to have epidural anesthesia/1% Lidocaine was infiltrated into the perineum/a pudendal block was placed). The patient was asked to push and the head delivered spontaneously in the (LOA/ROA/OP, etc.) position, over (an intact perineum/a midline episiotomy). The oropharynx and nasopharynx were then (bulb/DeLee) suctioned on the perineum. A nuchal cord was checked and (none/one) noted, and (relieved/delivered through/clamped and cut) around head as necessary. The anterior shoulder delivered easily and the posterior shoulder followed. The remainder of the infant was easily delivered and the oropharynx and nasopharynx was again bulb suctioned. The infant was noted to have spontaneous cry and spontaneous movement of all four extremities. The cord was clamped x 2 and cut and noted to have 2 arteries and one vein. The infant was passed to the (mother's abdomen/warmer) where (nursing/NICU) personnel were in attendance. (Cord blood and cord pH were then obtained). The placenta delivered intact (spontaneously/manual extraction) and the uterus (was/was not) explored. 20 units of Pitocin was placed in the IV bag to firm the uterus. Examination of the cervix and vaginal vault did not reveal any lacerations. A vaginal pack was then placed. Examination of the perineum showed (no lacerations/no extension of episiotomy/urethral tears, etc.) The (episiotomy/laceration) was repaired with 3-0 Vicryl in the normal fashion. The vaginal pack was then removed. The patient tolerated this procedure well, and recovered in L&D with her infant (or note if infant taken to NICU). All sponge and needle counts were correct. Dr. Staff was present for entire procedure.