CHAPTER 14

Pregnancy, Childbirth and the Puerperium

BASIC HEALTH RECORD

Discharge Summary Notes

All notes

Author	Service	Author Type	Filed	Note Time
MD	(none)	Physician	06/15/2008 0920	06/15/2008 0919

OB DISCHARGE SUMMARY

ADMISSION DATE: 6/12/2008

DELIVERY INFORMATION:
Date of Birth: 6/12/08

Time of Birth: 0806

Sex: Female

Infant Birth Weight :2580gm
Apgar: 8 at 1 minute, 9 at 5 minutes.

Infant Feeding preference: Breast

INTRA-PARTUM COMPLICATIONS:
Significant Events/Complications: None

POST-PARTUM COMPLICATIONS: edema and pre-eclampsia

DISCHARGE PLAN:
is a 30 y.o. female who will be discharged home in good condition.

PRINCIPAL DIAGNOSIS:
Patient Active Hospital Problem List:
BREECH PRESENTATION, DELIVERED (6/14/2008)
HX OF PERINATAL PROBLEMS (6/14/2008)

PROCEDURES PERFORMED:

EPISIOTOMY / LACERATION
Episiotomy: None
Laceration: None
Removal of All Vaginal Foreign Bodies: (not recorded)

MEDICATIONS:
Medications prior to admission that will be resumed at discharge:

Medication	Sig
• PRENATAL VITAMIN ORAL	daily

These are new, changed, or refilled medications at discharge:

Medication	Sig
• ACETAMINOPHEN 325 MG TAB	Take 1-2 325mg tablets by mouth every 4 hours for mild pain as needed.
• IBUPROFEN 600 MG TAB	1 tablet every 6 hours prn pain
• OXYCODONE-ACETAMINOPHEN 5 MG-325 MG TAB	Take 1-2 tablets by mouth every 4 hours for severe pain as needed
• OXYCODONE-ACETAMINOPHEN 5 MG-325 MG TAB	1-2 tablet Oral EVERY 4 HOURS AS NEEDED

DIET: Regular

ACTIVITY: As tolerated

CONTRACEPTION: not decided

FOLLOW-UP: 2 weeks

9:20 AM 6/15/2008

History and Physical

H&P Notes

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/09/2008 1642	06/09/2008 1642

S: 30 yl G3 P0110 presents at 38w5d for primary Cesarean delivery because of breech presentation. Patient declined external version; A-P course complicated by asymmetrical IUGR which improved with bedrest. Last US for growth showed appropriate growth at 14% with EFW 5lb6oz. AFI at last visit was 13; Patient has also had marked edema with total weight gain of 82 lbs despite normal glucola testing. Toxemia labs have consistently been reassuring with negative urine protein and reassuring LFT's, creatinine and platelet counts. Patient has had no other symptoms of preeclampsia except with edema.

OB labs: A Rh+; antibody negative; HIV NR; hep B NR; RPR NR; rub IM; glucola 121; GBS neg

OB history: 1/2007; NSVD of 27 week stillborn severely growth restricted fetus with possible smith-Lemli-Opitz syndrome; parents declined carrier status testing;

6/2007 First trimester spontaneous miscarriage With vacuum curettage

No Known Allergies.

Past Medical History

Diagnosis	Date
• stillbirth *27 week stillbirth with anomalies*	2006
• Missed Abortion *6 week size embryo*	6/25/2007
• High-Risk Pregnancy *History of 27 week fetal demise possibly due to Smith-Lemli-Opitz syndrome; 25% recurrence risk; EDD tentatively 1/18/2008 based on LMP MD patient .*	6/8/2007
• Intrauterine Death Affecting Management of Mother, Antepartum	11/29/2006
• Personal History of Perinatal Problems *History of stillbirth (27weeks) of anomalous growth restricted fetus with possible Smith-Lemli-Opitz syndrome Parents have declined genetic testing to confirm carrier status*	12/18/2007

Past Surgical History

Procedure	Date
• Surgical hx - neg	

Current outpatient prescriptions prior to encounter

Medication	Sig	Dispense	Refill
• PRENATAL PLUS 27-1 MG OR TABS	1 tablet every day	100	prn

]
History
Substance Use Topics

• Tobacco Use:	Never
• Alcohol Use:	No

Family History

Problem	Relation
• Anesthesia Reaction	Negative Family History
• Diabetes, Type II	Negative Family History
• Hypertension	Negative Family History
• Cancer, Breast	Negative Family History
• Cancer, Colon	Negative Family History

Problem list, past medical, surgical and family histories updated today. Patient denies fever, headaches, visual changes, nausea & vomiting, chest pain, dyspnea, abdominal pain, pelvic pain, abnormal vaginal bleeding or discharge; trouble with bowel or bladder or leg pain. Rest of review of symptoms also negative except for what has been mentioned previously.

O: BP 120/68 | Wt 182 lb 3.2 oz (82.645 kg) | LMP OB (6/21/08)

Patient appears alert, oriented, heatlhy, comfortable; HEENT unremarkable; thyroid symmetrical without lesion
chest clear;
CV regular rate and rhythm, no S3, S4 or murmur
back: no CVA tenderness or deformity;
breast exam is not repeated today;
abd: soft, liver & spleen normal; no masses or tenderness; FH c/w term pregnancy;
Pelvic: not repeated today;
UE and LE: 3+ edema generalized

A: 38w5d, breech presentation; severe gestational edema with preeclampsia; history of poor perinatal outcome;

P: Primary Cesarean for breech;

., MD

All notes

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/12/2008 0908	06/12/2008 0859

Preoperative Diagnosis: pregnancy, 38w5d, breech presentation; SGA
Postoperative Diagnosis: Pregnancy, 38w5d, delivered
Procedure: Primary low segment transverse Cesarean

Surgeon:
Assistant:
Anesthesia: spinal
Indications: This 30 yo P0110 presents at term for Cesarean because of breech presentation
Operative Procedure:
The patient was brought to the OR and administered regional anesthesia. Antibiotics were given IV now unless received recently. She was prepped and draped in the usual fashion for Cesarean Delivery.
A transverse abdominal skin incision was made and extended down to the fascial layer. A transverse fascial incision was made and extended bilaterally the length of the skin incision. The rectus muscle was dissected off the fascia in the midline inferiorly and superiorly. The recti were separated and the anterior parietal peritoneum was carefully entered and incised transversely. The vesico-uterine fold of peritoneum was incised transversely and the bladder gently dissected off the lower uterine segment to the extent possible. A low transverse uterine incision was made and extended both with blunt and sharp dissection. The breech was delivered easily through the incision aid of fundal pressure. This was followed with atraumatic delivery of the torso, shoulders and fetal head. A vigorous infant was delivered who had spontaneous cries on the OR table. DeLee and/or bulb suctioning was performed. After spontaneous cries were established the umbilical cord was doubly clamped and then divided and the infant delivered to the neonatal staff. Umbilical cord bloods were obtained and IV Pitocin was given. With fundal massage the placenta was delivered spontaneously to the uterine incision and then manually removed. Exploration of the uterine cavity was performed and no evidence of additional placental tissue was found. The uterine incision was repaired in two layers of 0 monocryl running suture. The second layer was used to imbricate the first layer. The vesico-uterine fold of peritoneum was approximated with 3-0 vicryl suture. The tubes and ovaries were inspected and appeared normal. Copious irrigation with saline or LR was utilized. The anterior parietal peritoneum was also repaired with 3-0 vicryl. The fascia was repaired with #0 PDS running from each corner and tying the separate sutures together in the midline. Interrupted 3-0 vicryl was used on the subcutaneous layer. Staples were used to approximate the skin. A dry sterile dressing was applied to the skin incision. Because of suboptimal involution of the uterus, EBL was 600cc. There were no complications.

MD

All Progress Notes continued

Author	Service	Author Type	Filed	Note Time
MD	(none)	Physician	06/13/2008 0841	06/13/2008 0840

CC: POD# 1 after cesarean delivery

S: no new c/o; denies nausea and/or vomiting; taking nutrition orally appropriately for this stage of recovery; ambulating, voiding, passing gas without difficulty; pain control adequate

O: BP 124/68 | Pulse 83 | Temp 98.8 °F (37.1 °C) | Resp 18 | Ht 1.524 m (5') | Wt 83.008 kg (183 lb) | SpO2 100% | LMP OB (6/21/08)

chest clear; CV reg R&R; ABD: soft; fundus firm, non-tender; incision and/or dressing is clean, dry and intact; lochia appears appropriate;
lower extremities symmtetrical without tenderness

hgb 11.4

A: stable POD# 1 after primary low segment transverse Cesarean
For breech presentation

P: continue present management
anticipated discharge Sunday (POD#3)

. MD

Author	Service	Author Type	Filed	Note Time
, MD	(none)	Physician	06/14/2008 0733	06/14/2008 0731

CC: POD# 2 after Scheduled primary cesarean delivery for breech

S: no new c/o; denies nausea and/or vomiting; taking nutrition orally appropriately for this stage of recovery; ambulating, voiding, passing gas without difficulty; pain control adequate

O: BP 120/55 | Pulse 89 | Temp 98 °F (36.7 °C) | Resp 16 | Ht 1.524 m (5') | Wt 83.008 kg (183 lb) | SpO2 100% | LMP OB (6/21/08)

chest clear; CV reg R&R; ABD: soft; fundus firm, non-tender; incision and/or dressing is clean, dry and intact; lochia appears appropriate; lower extremities symmtetrical without tenderness

Hgb not rechecked (>11 POD#1)

A: stable POD# 2 after primary low segment transverse Cesarean for breech; Severe gestational edema with preeclampsia; personal history of perinatal problems (first baby stillborn at 27 weeks)

P: continue present management
anticipated discharge Tomorrow or Monday;

MD

All Progress Notes

Progress Notes

All notes

Author		Service	Author Type	Filed	Note Time
	RN	(none)	NURS-Registered Nurse	06/15/2008 1330	06/15/2008 1329

C-Birth Discharge Note

Data:
Vital signs stable, afebrile, assessments within normal limits.

Pain was reported to be within patient determined acceptable limits.

Patient ambulates independently, is tolerating a regular diet, is voiding without difficulty, shows no signs of infection, incision is dry and intact, bowel sounds are present and patient is passing gas. Positive attachment behaviors are observed. Discharge outcomes on the care plan are met.

Action:
Review of care plan, teaching sheet and discharge instructions with mother.

Response:
Discharged at1230, Wheelchair