JOHNS HOPKINS
MEDICINE

Johns Hopkins Hospital

Operative Report

Name:	[redacted]	History:	0-469-86-79
Address:	[redacted] NJ [redacted]	Date of Operation:	08/13/2010
Phone:	(609) [redacted]	Service:	GYN
DOB:	10/27/1991		
Race:	African American		
Gender:	Female		
Attending Surgeon:	Kratz,Katherine Goodrich		
Assistant(s):	Khan,Michelle Joanne Khan,Michelle Joanne	Document No:	76564700020

Title of Operation:

Exploratory laparotomy.

Evacuation of partial fetus and products of conception.

Repair of hysterotomy secondary to uterine perforation during dilation and evacuation.

Evacuation of hemoperitoneum.

Small bowel resection by the General Surgery Team.

Indications for Surgery:

Ms. B[redacted] is an 18-year-old para 0 at approximately 21 weeks' gestation by a 21 week ultrasound in an outside hospital. She underwent an attempted dilation and evacuation procedure at an outside facility, during which uterine perforation occurred. During the dilation and evacuation, 2 fetal limbs and the placenta were reported to have been extracted. At the time of dilation and evacuation, bowel contents were noted in the uterus; therefore, bowel injury was suspected. She was transferred to Johns Hopkins Hospital for further management. On arrival at Johns Hopkins Hospital, she had tachycardia and abdominal tenderness. A bedside ultrasound demonstrated a uterus with a thick, homogeneous endometrium. The fetus was noted with in the abdominal cavity, posterior to the uterus. Ms. B[redacted] was taken to the operating room for a level 1 exploratory laparotomy and the General Surgery Team was notified of possible bowel injury.

Preoperative Diagnosis:

Uterine perforation status post dilation and evacuation, intraabdominal fetus, suspected bowel injury.

Postoperative Diagnosis:

Posterior uterine perforation, intraabdominal products of conception, defect in small bowel mesentery and incarceration of small bowel into uterus with approximately 50 cm of ischemic small bowel.

Anesthesia:

GETA.

Specimen (Bacteriological, Pathological or other):

Partial fetus and products of conception.

E[redacted] D[redacted] ([redacted])

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Surgeons Narrative:

Second Assistant: Lauren Elizabeth Patterson, M.D.

Intravenous Fluid: 3000 cubic centimeters crystalloid for Gyn portion of the procedure.

Estimated Blood Loss: 300 cubic centimeters for Gyn portion of the procedure.

Urine Output: 600 cubic centimeters, clear yellow for Gyn portion of the procedure.

Complications: None.

Findings: On examination under anesthesia: The patient was noted to have membranous material extruding from the vagina. On bimanual examination her cervix was approximately 3 cm dilated and her uterus was 2 cm below the umbilicus. At the time of laparotomy: Hemoperitoneum was present. A partial fetus was noted in the right upper quadrant along the paracolic gutter. This fetus was missing its right arm and right leg and portions of its abdominal contents and rib cage. There was no placenta noted within the abdomen or uterus. The uterine cavity was smooth upon manual exploration. There was a posterior uterine perforation, measuring approximately 4 cm. There was no disruption of the uterus anteriorly, and the bladder appeared within normal limits. The tubes and ovaries were normal bilaterally. The patient's small bowel extended through the uterine perforation into the uterus and into the vagina. The small bowel was dusky in appearance upon entry to the abdomen and the portion of small bowel extending into the uterus and vagina was pale and thin in caliber. Abdominal exploration revealed no other abnormalities.

Informed consent was obtained from the patient after risks, benefits and alternatives were explained. The possibility of hysterectomy and bowel resection including possible ostomy were discussed with the patient. She was taken to the general operating room. The General Surgery Team was notified preoperatively. She had received a dose of Zosyn prior to being transported to Johns Hopkins. She was given cefotetan pre-operatively. General endotracheal anesthesia was administered. Once anesthesia was found to be adequate, she was then placed in the dorsal lithotomy position using Yellowfin stirrups. Care was taken to position and pad her extremities to avoid injury. An exam under anesthesia was performed with the above-noted findings. She was then prepped and draped in the usual sterile fashion. A midline vertical skin incision was made with a scalpel from 2 cm above the pubic symphysis to 1 cm below the umbilicus. This was extended down to the fascia using Bovie electrocautery. The fascia was then incised in the midline with the Bovie on the cut function, and the fascial incision was extended superiorly and inferiorly using the Bovie on the cut function. The rectus muscles were separated in the midline. The peritoneum was identified and entered sharply using Metzenbaum scissors. This incision was extended superiorly and inferiorly with good visualization of the bowel and the bladder. Hemoperitoneum was noted on entry into the peritoneal cavity. The abdomen was explored with the above-noted findings. The bowel was packed away with moist laparotomy sponges. The partial fetus and all products of conception were removed from the abdomen and sent to pathology. The bowel was gently removed from the uterine cavity and covered with a moist laparotomy sponge. The general surgery team was called for immediate assistance with repair of the bowel.

The uterus was then manually cleared of all clot and debris with a moist laparotomy sponge. No products of conception were noted. The uterus was elevated through the abdominal incision. The uterus was repaired in 4 layers. The endometrium was closed using 3-0 Vicryl suture in a running fashion. The myometrium was then closed in 3 layers using 0 Vicryl sutures in a figure-of-eight fashion. The uterine serosa was reapproximated with 3-0 Vicryl suture in a baseball stitch. Excellent hemostasis was noted.

At this point, the General Surgery Team performed a small bowel resection and side-to-side anastomosis. Please see Dr. Wolfgang's operative note for full details of that procedure. The abdominal incision was closed by the General Surgery Team.

The patient tolerated the procedure well. She was extubated and taken to the recovery room in stable condition. Sponge, lap, needle and instrument counts were correct x 2. The attending, Dr. Kuatz, was present and scrubbed for the entire procedure.

,CLINICAL STAGE OF TUMOR:

Dictated By:

KHAN, MICHELLE JOANNE, M.D. 843889/430611354/MEDQ D:08/15/2010 12:32:02 T:08/15/2010 16:17:32

[redacted], D[redacted]

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SIGNED BY: KRATZ, KATHERINE
THIS DOCUMENT HAS BEEN ELECTRONICALLY SIGNED.

DATE AND TIME SIGNED: 08/18/2010 09:31 AM

Note: This operative note provides information pertaining only to the patient's most recent hospitalization. A more detailed medical history is available in the Medical Record.

[redacted]

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