conception groups, the risk of placenta previa (OD: 14.3%, AO: 5.6%, NC: 2.0%, p=0.049), placenta accrete (OD: 28.6%, AO: 8.9%, NC: 1.0%, p≦0.01) were higher. Moreover, compared with spontaneous conception group, the incidence of caesarian section (47.6%), postpartum hemorrhage(over 1,000mL) (61.9%), blood transfusion (19.0%), postpartum hysterectomy (9.5%) were higher in OD group.
Conclusion: Pregnancies by oocyte donation have increased risk of obstetrical complications including placental abnormality.

62.
EFFICACY OF THE DEDICATED NEEDLE FOR UTERINE COMPRESSION SUTURE AND BAKRI BALLOON FOR POSTPARTUM HEMORRHAGE WITH PLACENTA PREVIA

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Objective: We used a Sengstaken-Blakemore tube, rolled gauze and vertical compression suture (VCS) with an epidural needle for the management of postpartum hemorrhage (PPH) in cases of placenta previa (PP) and low-lying placenta (LLP) before 2014 in our institution. Since 2014, we have been using a dedicated needle for uterine compression suture (UCS) that was developed by our institution and a Bakri balloon for the management of PPH in cases of PP and LLP. This study aimed to evaluate the efficacy of the dedicated needle and Bakri balloon.
Methods: Cases of PP and LLP from January 2008 to March 2019 were retrospectively analyzed and included in the study. However, cases of placenta accrete were excluded. We divided the patients into two groups according to treatment period as follows: period 1 (from January 2008 to December 2013; 64 cases) and Period 2 (from January 2014 to March 2019; 121 cases). Surgical outcomes were then compared between the two groups.
Results: Significant improvements of surgical outcomes were observed in period 2 as compared with period 1 regarding the incidence rate of massive hemorrhage. (>3000 ml; 20.3% [13/64] vs. 7.4% [9/121], $P = 0.02$) and transfusion rate (32.8% [21/64] vs. 9.9% [12/121], $P < 0.001$).
Conclusion: Our study suggests that use of the new straight blunt needle dedicated for VCS and the Bakri balloon significantly improved the surgical outcomes in the cases of PP and LLP in this study.

63.
A CASE OF A TRILOBATE PLACENTA WHICH DETECTED AS A SUCCENTURIATE PLACENTA BY ULTRASONOGRAPHY DURING PREGNANCY

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Introduction: We were experienced succenturiate placenta by screening ultrasonography at pregnancy checkup. That placenta revealed trilobate after delivery.
Case: Gravida 2 Para 0, 38 years old pregnant patient has come to our facility after intracytoplasmic sperm injection - blastocyst transfer. She has a history of myomectomy 9 months before pregnancy. At the checkup of 21 weeks and 6 days of pregnant age, placentas of separated shape on anterior and posterior wall of uterus were detected by screening ultrasonography. By the ultrasound, it was observed that umbilical cord formed bridge between both lobes, and at the middle of the bridge, main cord was formed and extent to the fetus. At the bridge part, cord seemed it did not have a membranous part and free from supportive tissue by ultrasonography. After intimate pregnancy checkups, at 38 weeks and 2 days of pregnant age, elective cesarean section was performed. Neonate was 2560g male and Apgar score was 8/9 at 1 minute and 5 minutes after birth respectively. The umbilical arterial pH was 7.295. The placenta and cord were delivered without tearing or visible damage. The weight was 617gms and 25 X 16 cm. The shape of placenta revealed trilobite and the cord insertion manners showed marginal or velamentous according to lobes. The dimensions of lobes were 16 X 10 cm, 11 X 10cm, 6.5 X 4.5cm. The bridging part supported with membranous formation and there was no freely part of cord there. As histopathological findings, there were subchorionic fibrin deposit and calcification but no pathological damage on whole lobe like mass infarction or necrosis fortunately.
Discussion and conclusions: By some reports and papers, the frequency of succenturiate placenta is 0.16 to 1% and significantly higher observed in pregnancy after assisted reproductive technology. And it is regarded that the frequency of non-reassuring fetal status is significantly high. In some case, malformed placenta might influence to the prognosis of pregnancy and delivery, thus ultrasound screening on not only fetus and amniotic cavity but placenta and cord could be important.

64.
GESTATIONAL DIABETES(GDM) AS GREAT OBSTETRICAL SYNDROME(GOS)

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Object: We can refer to Gestational diabetes (GDM) as Great Obstetrical Syndrome (GOS) because GDM appears just during pregnancy but can develop into Diabetes Mellitus (DM) later in life. Likewise, babies delivered from mothers with GDM have health risks both soon after delivery and in later life.
There are three reasons why GDM can be considered GOS

1 - In Japan after HAPO study, diagnosis of GDM became more accurate. Before the HAPO study around 1 to 3% of all pregnancies showed GDM, but after the study, this rose to around 10 to 15%.
2 - The number of women with GDM who go on to develop problems later in life is high, which is why we need to be aware of this at the time of pregnancy. Pregnancy can be considered a stress-test for later life.
3 - A high rate of babies born to mothers with GDM develops RDS, hyperglycemia, hyperbilirubinemia, and so on. Later in life they may develop Cardio Vascular Disease (CVD) and DM.

In this study I confirm these three points through placental pathology.
Method: I studied 239 cases of GDM, diagnosed by 75g of OGTT, over a period of 6 years.
In each of the 239 cases, I checked the clinical record and examined the placenta.
GDM is defined by even one-point positive in three glucose level checks, with the base being 92 at 0 minutes and then, after oral glucose,180 at 60 minutes, and 153 at 120 minutes.
Results: From the 239 cases, by microscopic examination, I diagnosed
57 cases of thrombosis in decidua -23.8% Maternal side
40 cases of villous vessels abnormality -16.7% Baby's side
Conclusions: In the past we did not have the opportunity to examine a large number of GDM placentas, but with this study I examined 250 placentas over a six-year period, demonstrating an increase in awareness of the importance of placental pathology in GDM. This shows a change in thinking among obstetricians.
Secondly, in this study I showed through placental pathology, that mother's vessels problems during pregnancy can continue to have an impact on cardiovascular disease later in life.
Thirdly, this study showed that vascular problems in the mother can also continue to have an effect in later life on cardiovascular disease in the baby.
Placental pathology is basically for the mother and baby, but it is also a vital tool not only for obstetricians, but also for internal medicine and pediatrics. That is why GDM can be referred to as GOS.