347 STERILE VS OPEN BOX GLOVES: HOW CLEAN IS CLEAN? SHERRI JACKSON[1], MARGIE MORGAN[2], ANGELA SHAY[1], STEPHEN NICHOLS[2], MATTHEW KIM[1], [1]Cedars-Sinai Medical Center, Division of MFM, Department of Ob/Gyn, Los Angeles, California, [2]Cedars-Sinai Medical Center, Dept.of Pathology and Laboratory Medicine, Los Angeles, California

OBJECTIVE: In most labor and delivery units in the United States, vaginal exams are performed with single packaged sterile gloves. As the fiscal and environmental costs of modern healthcare are analyzed, interest in using open box gloves for vaginal exams has increased. In this pilot study, we evaluated a sample of open-box gloves found in labor and delivery as potential fomites.

STUDY DESIGN: In a sterile fashion, aerobic cultures were obtained of open-box gloves from 10 labor and delivery rooms. Positive (computer keyboard) and negative (sterile packaged glove) controls were also sampled. Incubation prior to identification was 48 hours.

RESULTS: Culture of the sterile glove had no growth. Keyboard and computer mouse cultures revealed common environmental bacteria: ***Pseudomonas sp., Stenotrophomas maltophilia,*** coagulase negative ***Staphylococcus,*** viridans ***Streptococcus, Bacillus sp.,*** and ***Ewingella americana.***

CONCLUSION: None of the identified bacteria were of high virulence. However, the potential for introducing virulent pathogens from grossly contaminated gloves, given endemically poor compliance to handwashing in hospitals, cannot be discounted. These results suggest that open box gloves although protective of the wearer, may not be clean enough for use in bacteria advantageous circumstances.

Culture Results

Culture Source	Identified Organisms
LDR 1	*Bacillus sp,* Coag Neg *Staph* (CNS)
LDR 5	*Pseudomonas stutzeri*
LDR 6	NO GROWTH
LDR 7	CNS, *Bacillus sp.*
LDR 8	*Bacillus sp.*
LDR 9	CNS, *Pseudomonas oxyzihabitans,* fungal sp.
LDR 10	*Micrococcus*
LDR 11	CNS, *Bacillus sp.*
LDR 20	viridans *Strep*
LDR PACU	CNS, viridans *Strep, Sphingomonas pauciimobilus*

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348 PLACENTAL PATHOLOGIES ASSOCIATED WITH INTRAUTERINE GROWTH RESTRICTION WITH AND WITHOUT OLIGOHYDRAMNIOS LIAT APEL-SARID[1], AMALIA LEVY[2], GERSHON HOLCBERG[3], EYAL SHEINER[3], [1]Soroka University Medical Center, Departments of Pathology, Beer-Sheva, Israel, [2]Ben-Gurion University of the Negev, Epidemiology, Beer Sheva, Israel, [3]Soroka University Medical Center, Ben-Gurion University of the Negev, Ob/Gyn, Beer Sheva, Israel

OBJECTIVE: To compare placental pathologies and perinatal outcomes in intrauterine growth restriction (IUGR) pregnancies with and without oligohydramnios.

STUDY DESIGN: A retrospective cohort study was performed, comparing all singleton deliveries with IUGR. Comparison of placental findings was performed between pregnancies with and without oligohydramnios. Oligohydramnios was defined as amniotic fluid index<5. When one or more of the following pathologies were found in microscopic examination of the placental tissue, the term uteroplacental insuffiency was defined: placental infarct, fibrosis of chorionic villi, thickening of blood vessels and poor vascularity of the chorionic villi.

RESULTS: Macroscopic placental finding were available for 1104 singleton IUGR pregnancies, and 397 placentas had microscopic examinations. Of these, 89 placentas were of IUGR neonates who had oligohydramnios. No significant differences in placental findings of uteroplacental insuffiency were found between pregnancies with and without oligohydramnios (69.3% vs. 74.3%; P=0.357). Likewise, no significan differences were noted between the groups regarding diffuse villous fibrosis (10.1% vs. 4.9%; P=0.573), and amnion cell metaplasia (65.9% vs. 64.3%; P=0.779). Cases of IUGR complicated with oligohydramnios had significant higher rates of perinatal mortality (9.9% vs.5.9%; P=0.028), preterm deliveries (34.9±3.4 vs. 35.4±3.1weeks of pregnancy; P=0.041) and lower birth weight (1737±542 grams vs. 1845±467 grams; P=0.002) as compared to IUGR without oligohydramnios.

CONCLUSION: Oligohydramnios is a significant risk factor for adverse perinatal outcomes in IUGR pregnancies. Nevertheless, no significant differences in placental pathologies are noted while comparing IUGR pregnancies with and without oligohydramnios.

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349 PLACENTA PREVIA: RESOLUTION BY THE THIRD TRIMESTER TERESA N. SPARKS[1], YVONNE W. CHENG[1], TANIA ESAKOFF[1], LENA KIM[1], AARON B. CAUGHEY[1], [1]University of California, San Francisco, San Francisco, California

OBJECTIVE: To determine the proportion of placenta previas that resolve after detection at first ultrasound (US).

STUDY DESIGN: A retrospective cohort study of women with placenta previa detected on first US at our institution from 2001-05. The primary outcome was resolution of placenta previa by third trimester on follow-up US after identification of previa on first US at 18-20 weeks. Chi-square tests were done to compare proportions of previas that resolved, with stratification by previa type and parity. Multivariable logistic regression was used to generate adjusted odds ratios (aOR).

RESULTS: Of the 1,474 US records reviewed, 20 complete previas were identified on first US, as well as 3 partial previas and 61 marginal previas. Thus, the baseline rates of previa in our patient population were 1.4% for complete previa and 4.1% for marginal previa. The majority of both complete and marginal previas resolved in the interval between first US and third trimester US (see table). Nulliparous women demonstrated an aOR of 0.46 (95% CI 0.23-0.92) for having complete previa in the third trimester, whereas multiparous women had an aOR of 2.2 (95% CI 1.09-4.38) for the same after controlling for age, parity, and prior cesarean delivery.

CONCLUSION: The majority of both complete and marginal previas resolved in the interval between first US and the third trimester, and multiparous women were more likely to have continued placenta previa into the third trimester. Understanding patterns of previa resolution enables providers to better counsel patients, as well as to plan for management of labor.

Placenta previa resolution between first US and third trimester (*p<0.05)

	Complete resolution	No resolution
Complete previa	58.8% *	23.5% *
Marginal previa	92.5% *	7.5% *
Complete previa among nullips	66.7% *	22.2% *
Complete previa among multips	50.0% *	25.0% *

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350 DOES EDUCATION LEVEL INFLUENCE REQUEST FOR ELECTIVE REPEAT CESAREAN DELIVERY AMONG WOMEN WITH A PREVIOUS CESAREAN DELIVERY? AUDREY GILBERT[1], WILLIAM FRASER[2], ALICE BENJAMIN[1], HAIM ABENHAIM[3], [1]McGill University, Montreal, Quebec, Canada, [2]Ste-Justine, University of Montreal, Montréal, Quebec, Canada, [3]Jewish General Hospital, McGill University, Montreal, Quebec, Canada

OBJECTIVE: Patient education level has been shown to affect health care access in a variety of different clinical contexts. The aim of this study is to demonstrate whether maternal education level plays a role in scheduling and having a planned elective repeat cesarean delivery rather than attempting a vaginal birth after caesarean section (VBAC).

STUDY DESIGN: We conducted a retrospective cohort study on all women with a previous cesarean delivery who delivered at the Royal Victroia Hospital between 2001 and 2006. We defined our exposure based on years of education: 11 years (up to and including a high school diploma), 12-15 years (some college/university education), and 16 (university degree). We used an unconditional logistic regression to calculate an age adjusted estimate of the risk of having a planned cesarean delivery.

RESULTS: Among 18,673 births in our cohort, 1,910 deliveries were in women with a previous cesarean delivery of which 12.6% had a high school degree or less, 38.3% had some college/university education, and 49.1% had a university degree. As compared to women whose maximum education was a high school diploma, there was a higher rate of planned cesarean delivery in women with some college/university education, OR 1.38 (1.00-0.89), p=0.047, and women with a university degree, OR 1.42 (1.04-1.94), p=0.03.

CONCLUSION: Although the mechanism is unclear, education appears to be a determinant of obstetrical management in women with a previous cesarean delivery.

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