late toxicosis and clinical recovery of pregnant women. The use of targeted and corrective and supportive treatment of late toxicosis of pregnant women is not only justified but also necessary. Naturally, the proposed principles of treatment and rehabilitation measures do not solve this problem, but attempts to accelerate the regression of toxicosis, prevent recurrence and achieve more complete rehabilitation of impaired functions during pregnancy seem appropriate to us. It is in this that we see the reserves for a possible improvement at the end of pregnancy and childbirth for mother and fetus.

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PLACENTAL MORPHOMETRIC INDICES IN WOMAN WITH PLACENTAL DYSFUNCTION

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Placental dysfunction (PD) is a key problem of obstetrics, neonatology and pathological anatomy, diseases of ante- and perinatal period, since functional failure of this organ leads to threatening miscarriage, fetal growth and developmental retardation (FGDR) or its death.

A morphometric study of placentas from 30 lying-in women, who had the background of placental dysfunction (study group) and 25 lying-in women with physiological pregnancy (control group) in gestation period of 36-40 weeks was carried out. Methodical recommendations on placental morphometry methods, introduced by A.P. Milovanov and A.I. Brusylovsky, were used in the study.

Having assessed the form of placentas, we found out that in women with placental dysfunctional complications the placentas were round in shape in 7 (28%) cases, whereas in women with physiological pregnancy this morphological parameter was observed in 19 (63.3%). 18 (72%) placentas in the main group were oval; it's twice higher than the same parameter in control group – 11 (36.7%).

Studying the umbilical attachment variations we researched that in women with placental dysfunction central attachment occurred only in 8 (32%) lying-in women, and in women with physiological pregnancy course it was noted in 18 (60%). Lateral umbilical cord attachment was observed in 13 (52%) pregnant of the main group, but in physiological pregnancy only 10 (33,3%) pregnant had this variation of umbilical attachment. The marginal attachment rate is rather high in women with PD in comparison with the control group – 4 (16%) to 2 (6.8%). According to the literature data, such umbilical cord attachment anomalies are accompanied by dysplastic changes of bloodstream and restriction of compensatory-adaptive reactions of the placenta.

An average weight of the placenta in patients with placental dysfunction was 388.58 ± 12.4, in the control group – 492.8 ± 24.4% ($p < 0.05$). Difference between an average weight indices and gestation norm probably may occur due to the fact that the effective implementation of the placenta compensatory-adaptive reactions is possible only with adequate functioning of the utero-placental vessels. An average area of the placenta in the lying-in women of the main group was 241.21 ± 5.16 cm, in the control group – 234.8 ± 5.2 cm. The tendency of the placentas to become thinner was also observed – 1.77 ± 0.2 cm and 1.9 ± 0.4 cm. Macroscopically the afterbirth flattening and thinning was observed in this pathology.

Placental-fetal index (PFI) in the main group was 0,138±0,003, and in the control group 0.159±0.009, that indicates a reduction in the volume of placental tissue per weight unit of a newborn with the placental dysfunction. External examination of placentas of the main group of patients showed the isolated bleeding centers on the maternal surface, frequent calcifications, deep cotyledon divisions.

The analysis of placentas morphometric peculiarities showed that in women with placental dysfunction placentas differ in shape, among which oval is dominant. The eccentric umbilical cord attachment is more frequent; flattening and thinning of the afterbirth occurs, it indicates reduction of weight, size and thickness of the placenta.