Medicare payment differences by gender and specialty training track of FPMRS surgeon.

MATERIALS AND METHODS: Medicare payments from the Provider Utilization Aggregate Files were used to determine the payments made by Medicare to urogynecologists. This database was merged with the NPI registry with information on subspecialty training and years since graduation, along with the geographic pricing cost index to account for Medicare payment adjustments. Physicians with <90% female patients, and graduated medical school <7 (OBGYN) and <8 years ago (urology) were excluded. Effects of gender, specialty of training, number of services, years of practice, and geographic pricing cost index on physician reimbursement were evaluated using linear mixed modeling.

RESULTS: There were 578 surgeons with FPMRS subspecialty training met inclusion criteria. Of those 517 (89%) trained as gynecologists, while 61 (11%) trained as urologists. 265 (51%) of the gynecology trained surgeons were women, and 39 (80%) of urology trained surgeons were women. Among urology trained surgeons the median female surgeon was paid $85,962 while the males were paid $121,531, or a 41% difference in payments, while women urology trained FPMRS surgeons performed a median of 1,135 services, while male surgeons performed a median of 1,793 services or a 57% difference in volume. Among gynecology trained surgeons the median female payments were $59,277 while performing 880 services, and male gynecology trained surgeons received a median of $66,880 and performed 791 services, representing a difference of 12% in payments and 11% in services. Male physicians were paid more than female physicians while controlling for specialty training, number of services, years of practice, and geographic pricing cost index.

CONCLUSION: Despite Medicare payments being based on an equation, differences in reimbursement by physician gender continue to exist in FPMRS. Female surgeons in FPMRS receive lower payments from Medicare. The differences in reimbursement could not be solely explained by differences in patient volume, area of practice, or years of experience, suggesting that similar to other fields in medicine, women in FPMRS are not paid as much as male physicians.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Frank I. Jackson: Nothing to disclose; Alexandra Dubinskaya: Nothing to disclose; Philip Labrias: Nothing to disclose; Jonathan Shepherd: Nothing to disclose.

12 Postoperative pain reduction following regional pudendal block with liposomal and plain bupivacaine after posterior colporrhaphy: A double-blinded, randomized controlled trial

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OBJECTIVES: To compare the effect of preoperative regional pudendal nerve block using a combination of liposomal and plain bupivacaine versus plain bupivacaine alone on vaginal pain after posterior colporrhaphy in reconstructive surgery on postoperative days (PODs) 1, 2, and 3.

MATERIALS AND METHODS: This was a double-blinded, randomized controlled trial conducted from August 2018 to August 2020 that included patients undergoing a posterior colporrhaphy, either independently or in conjunction with other vaginal or abdominal reconstructive procedures. Patients were block randomized to receive either 20 ml of a combination of liposomal and plain bupivacaine (study) or 20 ml of plain bupivacaine (control) in a regional pudendal block prior to the start of surgery. The Investigational Pharmacy maintained double-blinding by covering four 5 ml syringes containing the randomized local anesthetic. After induction of anesthesia, a pudendal nerve block was performed (5 ml superiorly and 5 ml inferiorly at each ischial spine) using a pudendal kit. The primary outcome was to evaluate postoperative vaginal pain using a visual analog scale on PODs 1, 2, and 3. Secondary outcomes included total analgesic medication usage through POD 3, postoperative voiding, defecatory dysfunction, and the impact of vaginal pain on quality-of-life factors. Repeated pain measurements were evaluated using a mixed effect model. Continuous differences were
evaluated with an exact Wilcoxon rank sum test and categorical differences were evaluated using Fisher’s exact test.

**RESULTS:** One hundred and twenty patients were enrolled (60 in each group). There was no significant difference in demographic data to include baseline vaginal pain. Postoperative vaginal pain scores were significantly lower in the liposomal/bupivacaine group versus the plain bupivacaine group. Scores are reported as medians on POD 1 (liposomal 0 [0-2], plain 2 [0-4], P = 0.03), POD 2 (liposomal 2 [1-4], plain 3 [2-5], P = 0.05), and POD 3 (liposomal 2 [1-4], plain 3 [2-5], P = 0.02). As expected, vaginal pain scores increased from POD 1 to POD 2, 3 in both groups. There was a significant decrease in ibuprofen (P = 0.01) and acetaminophen (P = 0.03) usage in the liposomal group; however, no significance in total opioid consumption through POD 3 (P = 0.82). There was no difference in successful voiding trials (liposomal 72%, plain 82%, P = 0.30), return of bowel function (P > 0.99), or quality of life factors (sleep, stress, mood, and activity).

**CONCLUSION:** Preoperative regional pudendal anesthesia with a combination of liposomal and plain bupivacaine provided more effective vaginal pain control versus plain bupivacaine alone for reconstructive surgery that included posterior colporrhaphy. Given notable benefit, this block should be considered for multi-modal pain reduction in this patient population.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:
Katherine L. Dengler: Nothing to disclose; Eric R. Craig: Nothing to disclose; Angela M. Dicarlo-Meacham: Nothing to disclose; Eva K. Welch: Nothing to disclose; Daniel I. Brooks: Nothing to disclose; Christine M. Vaccaro: Patty Brisben Foundation, Paid medical advisory board, Board Member; Daniel D. Gruber: Nothing to disclose.

13 The impact of preoperative pelvic pain on outcomes after vaginal reconstructive surgery
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**OBJECTIVES:** To compare outcomes after vaginal reconstructive surgery between women with and without preoperative pelvic pain.

**MATERIALS AND METHODS:** Baseline and postoperative data were analyzed from the Outcomes Following Vaginal Prolapse Repair and Midurethral Sling (OPUS) multicenter trial. The trial involves women with anterior prolapse without symptoms of stress incontinence randomized to receive either a midurethral sling (MUS) or sham incisions during surgery. Participants completed the visual analogue pain scale adapted for suprapubic pain (VAS) and Pelvic Floor Distress Inventory (PFDI) questionnaire at baseline, 3 months, and 12 months. Preoperative pelvic pain was defined as a response of “5” or greater on pain VAS or answering “moderately” or “quite a bit” on the PFDI question “do you usually experience pain in the lower abdomen or genital area?” Outcomes and complication rates were compared between women with and without pelvic pain.

**RESULTS:** OPUS participants included 112 women with pelvic pain (58 had MUS and 54 had sham incisions) and 212 women without pelvic pain (105 had MUS and 107 had sham incisions). Women who had a MUS and pelvic pain were younger than women without pelvic pain (60.3 ± 12.1 vs 65.1 ± 8.6; P < 0.001). Women who had sham incisions and pelvic pain were more likely of Hispanic ethnicity than those women without pelvic pain (27.8% vs 9.4%; P < 0.001). Women with pelvic pain had greater improvement on pain VAS scores post-surgery at 3 months (-3.1 ± 2.9 vs -0.4 ± 1.6, P < 0.001) and at 12 months (-3.4 ± 3.0 vs -0.6 ± 1.6, P < 0.001) compared to those without pain. Similar improvements were present on the PFDI and pelvic floor impact questionnaires. The differences observed were not affected by whether women were in the MUS or sham arm of the trial. Urinary tract infection, mesh erosion, and incomplete bladder emptying did not differ between groups.

**CONCLUSION:** Women with preoperative pelvic pain experience significant improvements in pain and pelvic floor symptoms with vaginal reconstructive surgery. Reassuringly, performance of a MUS did not have an impact on these results.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Elisabeth C. Sappenfield: Nothing to disclose; Paul Tulikangas: Nothing to disclose; Rui Wang: Nothing to disclose.

14 Development and validation of the value of uterus (VALUS) instrument for women undergoing pelvic organ prolapse surgery
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**OBJECTIVES:** Currently, there are no validated instruments to quantify a woman’s valuation of her uterus. The objective of this study was to develop a reliable and valid instrument to measure a patient’s value of her uterus.

**MATERIALS AND METHODS:** Value of Uterus (VALUS) is a 9-question instrument that was developed based on existing literature and the authors’ experience with uterine preservation (Figure 1). For content validity, VALUS was reviewed by 2 OB/GYN specialists and 6...