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.

The impact of preoperative pelvic pain on outcomes after vaginal reconstructive surgery

E. C. Sappenfield, P. Tulikangas, R. Wang
Hartford Hospital, Hartford, CT

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.

Development and validation of the value of uterus (VALUS) instrument for women undergoing pelvic organ prolapse surgery

O. H. Chang, M. D. Walters, M. Yao, B. Lapin
Cleveland Clinic, Cleveland, OH

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 specialists.
urogynecologists. To validate the instrument, we recruited women over 45 years old with uterovaginal prolapse undergoing vaginal surgery with or without hysterectomy. We excluded women who desired future childbearing, or those with contraindications to uterine preservation. Internal reliability of the instrument was measured with Cronbach’s alpha. For known groups validity, VALUS summary scores were compared between women in the hysteropexy versus hysterectomy groups using t-test. For convergent validity, in the absence of preexisting tools to measure uterine preferences, Pearson correlation coefficient evaluated the correlation between VALUS with a visual analogue scale (VAS): “how important is it to you to keep your uterus when you have a gynecologic condition?” Intra-class correlation coefficient was used to assess test-retest reliability with VALUS administered to women twice over the span of 1-4 weeks. Lastly, a receiver operating characteristic (ROC) curve analysis was conducted to identify a cut-off VALUS score for predicting whether a woman would undergo hysteropexy (versus hysterectomy).

RESULTS: Forty patients were recruited (26 patients in the hysterectomy group and 14 patients in the hysteropexy group), with a mean age of 64 ± 10 years. There were 89.5% of the patients who identified as White/Caucasian. There were no differences in demographics between women who underwent hysterectomy versus hysteropexy. Cronbach’s alpha was 0.90, suggesting excellent internal consistency of the items in the VALUS instrument. Patients in the hysteropexy group had significantly higher VALUS scores (indicating greater value placed on the uterus) compared to women who underwent hysterectomy (29.5 vs. 18.9, P < 0.001). The VALUS instrument was highly correlated to the VAS question (r = 0.80, 95% CI = 0.65-0.89, P < 0.001). Test-retest reliability was good (ICC = 0.88) in 33 women who completed the instrument twice. ROC curve analysis revealed a VALUS cut-off score ≥23 had good accuracy for predicting hysteropexy (area under the curve = 0.89; sensitivity = 100%; and specificity = 76%).

CONCLUSION: VALUS is a reliable and valid 9-item instrument that measures a woman’s valuation of her uterus. VALUS was shown to reliably predict the type of procedure the patient undergoes. This can be a helpful tool to aid both the patient and her physician on selecting treatment options.

VALUE OF UTERUS (VALUS)

Please let us know your level of agreement with each of the items below.

The uterus is important for (check one answer for each item)

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neutral (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1.</td>
<td>My sexual function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q2.</td>
<td>My sexual pleasure</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Q3.</td>
<td>My sense of self</td>
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<tr>
<td>Q4.</td>
<td>Staying complete as a woman</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Q5.</td>
<td>Staying complete as a person</td>
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<tr>
<td>Q6.</td>
<td>My relationship with my partner</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Q7.</td>
<td>Weight control</td>
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</tbody>
</table>

The removal of my uterus can potentially (check one answer for each item)

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Disagree (1)</th>
<th>Disagree (2)</th>
<th>Neutral (3)</th>
<th>Agree (4)</th>
<th>Strongly Agree (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q8.</td>
<td>Make me go into menopause</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q9.</td>
<td>Require hormones (if menstruated)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Question 9 is reversely scored. To calculate the total VALUS score, add up the scores for Q1 through Q8 and (9-Q9).

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:
Olivia H. Chang: Nothing to disclose; Mark D. Walters: Nothing to disclose; Meng Yao: Nothing to disclose; Brittany Lapin: Nothing to disclose.

15 Outcomes following same-day discharges following minimally invasive prolapse surgery

C. Bretschneider1, D. Luchristt2, K. Kenton1, D. Sheyn3

1Northwestern University, Chicago, IL, 2Duke University, Durham, NC, 3University Hospitals, Cleveland, OH

OBJECTIVES: To describe outcomes and assess factors associated with complications following same-day discharge for minimally invasive surgery (MIS) for prolapse (POP).

MATERIALS AND METHODS: Using the American College of Surgeons National Surgical Quality Improvement Program (NSQIP) database, we identified women undergoing POP surgery between 2012 and 2018 who were discharged on postoperative day 0 (POD0) or 1 (POD1) using postoperative diagnosis code. Procedure codes were used to select patients who underwent MIS. Patient and procedural characteristics as well as readmission, reoperation, and 30-day postoperative complications (POCs) were abstracted. Descriptive statistics were used to describe the cohort, and bivariate analyses were performed to describe differences between patients discharged on POD0 and POD1. Multivariable logistic regression (MVLR) was used to determine the role of day of discharge on POC, readmission and reoperation controlling for potential confounders.

RESULTS: There were 23,540 patients who met inclusion criteria: 19% patients were discharged POD0, while 81% were discharged POD1. The mean ± SD age for the cohort was 61 ± 12 years with a median (IQR) body mass index (BMI) of 28 (25-32) kg/m². The majority was white (90%) with an ASA class 2 (68%), and nearly half had a major medical comorbidity (43%). Overall complication rate was 5.5%; UTI was most common (3.9%) followed by superficial surgical site infection (SSI) (0.5%) and organ/space SSI (0.4%). Table 1 shows differences in characteristics between the two cohorts. Of note, patients discharged on POD0 had lower rates of POC compared to those discharged on POD1 (4.8% vs 5.6%, P = 0.04); however, no differences in readmission (1.6% vs 1.9%, P = 0.1) or reoperation rates (1.1% vs 1.1%, P = 0.74) were found in patients discharged POD0 or POD1. In MVLR models controlling for age, race, BMI, ASA class, procedure type, and operative time, day of discharge was not independently associated with increased odds of POC (aOR = 0.99, 95% CI = 0.85-1.16) nor was increased odds of reoperation (aOR = 1.1, 95% CI = 0.80-1.54); however, POD1 discharge was associated with decreased odds of readmission (aOR = 0.71, 95% CI = 0.66-0.77). Interaction analysis showed no differences in risk factors in risk factors for POC, reoperation and readmission between the POD0 and POD1 groups.

CONCLUSION: After controlling for confounders, same-day discharge was not associated with increased odds of postoperative complications or reoperation in women undergoing MIS for POP; however, it was associated with increased odds of readmission.