cohort: those who had a single operation and those who received a repeat operation, defined as any apical prolapse surgery or revision after initial prolapse surgery. We performed a logistic regression comparing the two cohorts to determine whether there was a difference in reoperation by urban versus rural hospital status, adjusting for confounders including sociodemographic variables with $P < 0.1$ on univariable analysis.

**RESULTS:** We identified 22,072 women within the database who underwent apical prolapse surgery. Five hundred fifty-four patients (2.5%) underwent a second surgery. The median age was 61 (interquartile range [IQR] = 50–70). The majority identified as white (85.7%) or black (4.8%), 5,473 (24.8%) were obese, and 2,143 (9.7%) had diabetes. The above variables were not different whether subjects had a single operation or repeat procedure. There was a lower rate of reoperation amongst patients with tobacco use (1.7% vs 2.6%, $P = 0.027$). There were also fewer reoperations for patients with concomitant incontinence procedures with their index surgery (1.8% vs 2.7%, $P < 0.001$). On univariable analysis, women who lived in rural areas were 1.93 times as likely to have a second surgery. After adjusting for confounders, this effect persisted on multivariable analysis (OR = 1.61, 95% CI = 1.31–1.98). Other variables that significantly reduced the risk of having a second surgery included anticholinergic use (OR = 0.67) and concomitant incontinence procedures with their index surgery (OR = 0.67). When compared to hospitals with bed size <5, there was an increased risk with bed size 200-299 (OR = 1.58) and a decreased risk with bed size 6-99 (OR = 0.67). Other bed sizes did not significantly impact reoperation. The full regression is summarized in Table 1.

**CONCLUSION:** In 22,072 women undergoing an apical suspension for correction of pelvic organ prolapse, those who have surgery in a rural hospital are 1.61 times as likely to have a second surgery.

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:** Saniya Ablatt: Nothing to disclose; Xi Wang: Nothing to disclose; Suman Sahil: Nothing to disclose; An-Lin Cheng: Nothing to disclose; Amelia Kirchhoff-Rowald: Nothing to disclose; Jonathan P. Shepherd: Nothing to disclose; Gary Sutkin: Nothing to disclose.

**25 Changes in utilization and safety profile of same day discharge for minimally invasive hysterectomy from 2008-2018**

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**OBJECTIVES:** To describe changes in same day discharges (SDDs) following minimally invasive hysterectomy (MIH) in a large diverse practice population and to assess if changes in utilization of SDD are associated with changes in postoperative complications or unplanned readmission.

**MATERIALS AND METHODS:** We performed a secondary analysis of the 2008-2018 National Surgical Quality Improvement Program (NSQIP) Database. MIH were identified by current procedural terminology (CPT) code and categorized by approach: laparoscopic (TLH), vaginal (TVH), or laparoscopic-assisted vaginal (LAVH). Individuals with an oncologic diagnosis or concomitant procedure other than adnexal surgery, or who were not discharged during the 30-day postoperative period were excluded from the analysis. Change in SDD was assessed over the 11-year analysis period using the Cochran-Armitage test for trend. Overall odds of unplanned readmission and composite measures of major or minor complications were assessed using logistic regression modeling, controlling for patient characteristics. Interaction terms were utilized to assess for temporal trends over the analysis period. Notably, due to missing data, only years 2011 to 2017 were evaluated for unplanned readmission. Secondary outcomes included superficial surgical site infection (SSI), any SSI, and urinary tract infection (UTI) among SDD.

**RESULTS:** There were 161,444 hysterectomies were included in the analysis. Over the 11-year period, there was an increase in SDD among all forms of MIH (Figure 1), with the largest increase seen within TLH (+22.3%). However, in 2018, same day discharge represented only 21% of MIH overall and utilization varied by surgical approach (TLH 31%; LAVH 18%; TVH 19%). When including discharge on post-operative day 1, the proportion of cases increased to 88.5 percent. Over the 11-year analysis period, no significant trends were seen in major or minor postoperative complications, while unplanned readmissions were significantly decreased (absolute RR = 0.36%; Cochran-Armitage Test $P = 0.019$). When compared to individuals discharged on postoperative day one, SDD was associated with 25% lower odds of readmission, and 22 and 26% reduced odds of major and minor complication respectively (Table 1).
CONCLUSION: The last decade has seen increased SDD among all forms of MIH, which was associated with significant reductions in readmission rates and major and minor complication. Moreover, there were no temporal trends noted within the analysis period, suggesting that the observed outcomes are not entirely attributable to selection bias among those offered SDD. These data suggest that SDD may have advantages over inpatient admission after MIH and can be safely expanded to a larger portion of individuals undergoing MIH.

Table 1. Odds of 30-day postoperative outcomes among those who were discharged same day following minimally invasive hysterectomy.

<table>
<thead>
<tr>
<th></th>
<th>Unadjusted OR</th>
<th>95% CI</th>
<th>Adjusted OR</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission</td>
<td>0.759</td>
<td>0.686-0.84</td>
<td>0.755</td>
<td>0.681-0.836</td>
</tr>
<tr>
<td>Cleften-Olindo III-V Complications</td>
<td>0.754</td>
<td>0.688-0.827</td>
<td>0.741</td>
<td>0.674-0.814</td>
</tr>
<tr>
<td>Cleften-Olindo I-II Complications</td>
<td>0.774</td>
<td>0.717-0.835</td>
<td>0.782</td>
<td>0.724-0.845</td>
</tr>
<tr>
<td>Superficial SSI</td>
<td>0.836</td>
<td>0.816-0.977</td>
<td>0.852</td>
<td>0.731-0.993</td>
</tr>
<tr>
<td>Any SSI</td>
<td>0.749</td>
<td>0.65-0.864</td>
<td>0.754</td>
<td>0.652-0.872</td>
</tr>
<tr>
<td>UTE</td>
<td>0.886</td>
<td>0.806-0.972</td>
<td>0.931</td>
<td>0.828-1.003</td>
</tr>
</tbody>
</table>

Model adjusted for age, body mass index, race/ethnicity, American Society of Anesthesiologists class, hypertension requiring medication, smoking within the last year, NSQIP functional status, presence of any major medical comorbidity, and uterine size.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Douglas Luchristt: Nothing to disclose; Kimberly Kenton: Nothing to disclose; C E. Bretschneider: Nothing to disclose.

26 Risk of obstetric anal sphincter injury by delivering provider type

T. V. Walker, A. D. Sparks, C. M. Carter-Brooks

OBJECTIVES: Obstetric anal sphincter injuries (OASIs) have significant short- and long-term effects including pain, anal incontinence, and sexual dysfunction. OASI is one of the few modifiable risk factors for anal incontinence, yet OASI complicate at least 8% of vaginal deliveries. There is a paucity of data examining delivering provider type as a risk factor. Our objective was to assess if the primary delivering provider, certified nurse-midwife versus physician obstetrician, is associated with OASI. We hypothesized more OASIs with midwives as the delivering provider.

MATERIALS AND METHODS: This was a secondary analysis of a multicenter, retrospective cohort study from the Consortium of Safe Labor. Included were nulliparous women who had a vaginal delivery of a singleton fetus at >37 weeks gestational age from 2002 to 2008. Women were excluded if delivery was complicated by shoulder dystocia or from sites without deliveries. Student t-tests, chi-squared tests, and Fisher's exact test were used as appropriate to assess baseline characteristics, labor factors, and OASIs. Multivariable logistic regression and propensity score matching analyses were performed to control for characteristics associated with OASI. Data are presented as adjusted odds ratio (aOR).

RESULTS: Of 228,668 births at 19 sites, a total of 2,735 births from 3 sites met inclusion criteria: 1,551 physician and 1,184 midwife births. Of all births, 4.24% (n = 116) were complicated by OASI. Physician patients were older (23 ± 5 vs 21 ± 4 years), there were more White patients (26.4% vs 14.3%), privately insured (39.1% vs 22.8%), with higher pre-pregnancy BMI (25.5 ± 6.4 vs 24.8 ± 5.8 kg/m²), more medical co-morbidities, labor inductions (40.9% vs 20.4%), labor augmentations (28.2% vs 16.2%), and episiotomies (15.5% vs 5.2%; all P < 0.05). Midwife patients had higher fetal gestational age (39.7 ± 1 vs 39.4 ± 1.2 weeks) and infant birth weights (3.3 ± 0.4 vs 3.2 ± 0.4 kg; all P < 0.05). OASIs were more common in physician compared to midwife births (5.9% vs 2.0%, P < 0.0001). This difference persisted on multivariable logistic regression with OASIs being 2.39 (95% CI = 1.5-3.9) times more likely with physician delivery when controlling for maternal history of heart disease (aOR = 3.9, 95% CI = 1.03-14.6), episiotomy (aOR = 3.1, 95% CI = 2.0-4.9), increasing maternal age (aOR = 1.08, 95% CI = 1.04-1.1), decreasing maternal BMI (aOR = 0.95, 95% CI = 0.92-0.99), non-White race (aOR = 0.61, 95% CI = 0.4-0.96), and increasing birthweight (aOR = 1.03, 95% CI = 1.02-1.05). Area under the curve for this model was 0.78 indicating strong predictive ability. With propensity score matching, OASIs remained higher amongst physicians compared to midwives (6.6% vs 1.8%, P < 0.0001) with an aOR of 3.8 (95% CI = 2.0-7.1).

CONCLUSION: OASIs were more common in physician compared to midwife deliveries even when controlling for other associated factors. Our model may be used as a pre-delivery tool to guide providers on OASIs risk and possible reduction strategies.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Taniya V. Walker: Nothing to disclose; Andrew D. Sparks: Nothing to disclose; Charelle M. Carter-Brooks: Nothing to disclose.

27 Withdrawn

28 Validation of prioritization scoring tools for triage of elective gynecologic surgery during the COVID-19 pandemic

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OBJECTIVES: The COVID-19 pandemic disrupted access to elective surgery. In order to resume surgeries, we implemented the medically-necessary time sensitive scoring tool (MeNTS) (Prachand et al. 2020) and the modified Elective Surgery Acuity Scale (ESAS) to help stratify overall risk of operating on an individual basis. However, these surgical tools have not been validated for gynecologic surgery. Our objective was to evaluate the internal validity and inter-rater reliability of these scoring tools using a cohort of our faculty gynecologic surgeons.

MATERIALS AND METHODS: To assess internal validity and inter-rater reliability of the MeNTS and ESAS scoring tools, faculty were asked to complete a scoring survey with a series of 5 de-identified patient cases and one fictitious case written and scored by the chairperson of the Department of Obstetrics and Gynecology. Faculty scores for the fictitious case were compared to the “expert” score given by our chairperson. This served to assess internal validity or accuracy of our study. Inter-rater reliability was assessed through faculty scoring of 5 de-identified patient cases. The reliability coefficient was determined using Cohen’s kappa.

RESULTS: To assess the accuracy of tools, we asked faculty to score a fictitious case written by the chairperson of our department, using the MeNTS and ESAS tier tools. Average scores were compared against the chairpersons’ “expert score” (Figure 1, Table 1). The MeNTS inter-rater reliability showed good agreement across 5 cases and 8 faculty raters, kappa coefficient = 0.626. The ESAS tier analysis showed poor inter-