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>Clavien-Dindo III-V</td>
<td>0.754</td>
<td>0.688-0.827</td>
<td>0.741</td>
<td>0.674-0.814</td>
</tr>
<tr>
<td>Complications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clavien-Dindo I-II</td>
<td>0.774</td>
<td>0.717-0.835</td>
<td>0.782</td>
<td>0.724-0.845</td>
</tr>
<tr>
<td>Complications</td>
<td></td>
<td></td>
<td></td>
<td></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 Lachrißt: 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. Walker¹, A. D. Sparks², C. M. Carter-Brooks¹
¹George Washington University School of Medicine and Health Sciences, Washington, DC, ²George Washington University Medical Faculty Associates, Washington, DC

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 multi-center, 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 analysis, 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 ± 1.1 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 = 1.04-1.11), decreasing maternal BMI (aOR = 0.95, 95% CI = 0.92-0.59), 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.

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

S. H. Guenin¹,², A. Soltani¹,², C. L. Grimes¹,², C. A. Clare¹,², G. David-West¹,², J. G. Keltz³, S. Menon¹,², S. S. Tedjarati¹,², T. Pradhan¹
¹New York Medical College, Valhalla, NY, ²Westchester Medical Center, Valhalla, NY, ³Metropolitan Hospital, New York, NY

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 fictitious cases and one fictitious case written by the chairperson of our department, using the 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.

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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