OBJECTIVES: The objective of this study is to identify relevant risk factors for development of abdominal and pelvic adhesions in women based on their prior medical and surgical history. The primary outcome of this study is the presence and severity of adhesions identified at the time of laparoscopy for benign gynecologic disease. METHODOLOGY: This multi-site prospective study was approved by local IRB board. All laparoscopic cases performed by study staff on adult patients were eligible for inclusion. The anticipated study size is a minimum of 1,000 cases in an effort to account for more rare adhesion-promoting conditions. Cases were performed per standard protocol with entry approach and location per surgeon preference. Intraoperative photo documentation of four abdominal quadrants was obtained at the onset of each case. Following the case, a survey form was completed (Fig 1) to capture data on adhesiogenic events, time spent for adhesiolysis, route of entry, location, and grade of adhesions (Fig 2), if present. RESULTS: Herein we present interval findings from study onset in 2019 until 2021. A total of 490 laparoscopic cases have been collected, with an overall adhesion incidence of 58.98%. The most common prior inflammatory event was presence of endometriosis; among the endometriosis cases with no prior surgeries, the adhesion incidence was 61.29%. The most common preceding abdominal surgical event was a Cesarean section, with 82 patients having one or more prior Cesareans. Adhesions were present in 87.8% of cases with prior Cesarean, predominantly in the lower or midcentral abdomen and requiring on average 18.5 minutes of adhesiolysis; 44.4% of the adhesions were classified as filmy, 33.3% as dense, and 22.2% as cohesive. The second most common laparotomic procedure was abdominal myomectomy (n=22), of which 90.1% had adhesions predominantly in the central lower pelvis. There was a relatively even distribution of adhesion types, requiring an average of 24.4 minutes of adhesiolysis. This is in contrast to the cases of laparoscopic myomectomy without prior abdominal surgery (n=10), of which 80% had adhesions noted in the lower or mid pelvis. These adhesions were filmy in 75% of the cases and required an average of 14.8 minutes for adhesiolysis. CONCLUSION: Our preliminary findings highlight the need for vigilance regarding anticipated intraabdominal adhesions. We anticipate that upon collecting a complete dataset, a model can be established for predicting risk factors for the development of abdominal adhesions. This project has important clinical implications and enables the provider to better counsel patients on rates of postoperative adhesion development, as well as guide operative decision-making for site of abdominal entry.


**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**
Sarah L. Raissier: Nothing to disclose; Shabnna Gupta: Nothing to disclose; Parmida Maghsoudlou: Nothing to disclose; Nisse Clark: Nothing to disclose; Mobolaji Ajaio: Nothing to disclose; Louise P. King: Nothing to disclose; James Greenberg: Nothing to disclose.

**29 Treatment of pelvic nerve dysfunction with a short course of pudendal nerve blocks and nsaid:**

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**OBJECTIVES:** Chronic pelvic pain (CPP) affects approximately 15% of women and is often difficult to treat.1 Most women with CPP have symptoms suggestive of multi-organ system involvement including gynecologic, gastrointestinal, urologic, and musculoskeletal causes with or without central nervous system sensitization. Musculoskeletal origin pelvic pain has been reported to be associated with 22% of women with CPP.2 It is described by many names, but a common finding is abnormal sensitivity of tissues in the distribution of the pudendal nerve. Local treatments for this include pelvic floor physical therapy, trigger point injections, and pudendal nerve (PN) blocks. However, there is limited data available on the use of PN blocks for treatment.2 For several years, we have offered patients with signs and symptoms of pelvic nerve dysfunction a short series of pudendal nerve blocks combined with continuous NSAID therapy for several weeks as initial therapy. We conducted a quality assurance review to determine the effectiveness of this therapy for pudendal nerve pain in our population.

**MATERIALS AND METHODS:** Patients were offered PN blocks if they had pudendal nerve tenderness on exam and this was considered to be a major component of their pelvic pain. Transvaginal PN blocks were completed in standard fashion using lidocaine 1%, 10 mL and triamcinolone, 40 mg/1 mL per side. Blocks were placed just medial to the ischial spine on the affected side(s) as illustrated in an RCOG publication.4 Medical records of patients treated with pudendal nerve blocks were identified using current procedural terminology coding and the Epic SlicerDicer tool. Demographic data and confounders were collected as well as the number of and response to PN blocks. Patients who underwent one block were excluded from this evaluation because their pain was either short-term and resolved or the block was not effective.

**RESULTS:** From May 2017-July 2021, 195 patients underwent 1 to 4 PN blocks. 73% of patients received two blocks or more blocks. Of the patients who received two or more blocks, 91% reported improvement in their symptoms after the first block, 100% reported improvement after the second block and 86% reported improvement after their third block. 64% of patients had symptoms documented consistent with other organ system involvement such as endometriosis, interstitial cystitis, irritable bowel syndrome and fibromyalgia.

**CONCLUSION:** Pudendal nerve dysfunction is a common component of chronic pelvic pain. A short series of 1-4 transvaginal PN blocks combined with NSAID therapy for several weeks can often successfully treat pelvic pain related to PN dysfunction. We found that the duration of pain relief generally increases after each block and is a safe and simple tool to treat CPP of musculoskeletal origin. Prospective studies on this should be considered to better establish long-term therapeutic success.

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**
Bruce Kahn: Nothing to disclose; Hannah Marshall: Nothing to disclose.

**30 Clinical utility of routine postoperative labs in same-day minimally-invasive hysterectomy**

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**OBJECTIVES:** Routine postoperative labs lack clinical utility in minimally invasive hysterectomy (MIH) when overnight observation is planned. As same-day discharge becomes more common, many providers use labs to compensate for the shorter observation period. We aim to describe the clinical utility of routine postoperative labs in same-day MIH.

**MATERIALS AND METHODS:** This is a retrospective chart review of all planned same-day MIH performed at two hospitals in an urban, academic health system from July 2, 2020 to July 1, 2021. Eligible patients had planned postoperative labs within 8 hours of surgical end time. Those converted to laparotomy or with concomitant non-gynecologic procedures were excluded. Demographic and clinical data were abstracted from medical records. Our primary outcome was rate of clinical interventions prompted by postoperative labs. Secondary outcomes included rates of major (blood transfusion, reoperation, overnight observation) and minor interventions (repeat labs, imaging, electrolyte repletion), and readmission within 30 days. Concerning clinical signs included HR≥100 bpm, SBP<90 mmHg or DBP<60 mmHg for >30 minutes, minute output <0.5 mL/kg/hr, persistent dizziness, nausea/vomiting, or uncontrolled pain despite standard analgesia.

**RESULTS:** Two hundred forty-six patients met criteria and were included. Mean age, BMI, and preoperative hemoglobin were 54.8yrs (±12.7), 30.76 kg/m² (±6.8), and 12.4 g/dL (±1.6), respectively. Median Charlson Comorbidity Index was 2 (IQR 0-3). MIH were performed most commonly for known/suspected malignancy (41.1%) and via robot-assisted laparoscopy (85.4%). There were 44 (17.9%) total interventions among 32 (13.0%) patients. The majority were minor (41, 93.2%). The most common minor interventions were repeat labs (21, 47.7%) and electrolyte repletion (17, 38.6%). Of those