

Statistical analyses were completed using chi-square tests for categorical variables and analysis of variance (ANOVA) for continuous variables.

**RESULTS:** There were a total of 1,313 hysterectomies. Twenty four cases were removed due to exclusion criteria. 1,267 were total laparoscopic hysterectomies (TLH), among which 19% were tier 1, 32% were tier 2, and 28% were tier 3 complexity. When assessing readmission rates, emergency department visits, and urgent care visits, there were no statistically significant differences by complexity tier. Among TLH, there were a total of 70 (5.5%) complications among 59 patients. The primary complications observed were wound complications (17, 1.3%), transfusions (10, 0.79%), and perforated viscus (10, 0.79%). There was a conversion rate of 1.1%. There was no difference in complication rate by tier for TLH; however, looking at converted cases, there was an increased complication rate for Tier 3 cases ( $p < 0.01$ ). Tier 3 cases were associated with higher rates of admission and conversion to open, as well as longer procedure lengths and increased estimated blood loss.

**CONCLUSION:** While surgical complexity was associated with higher admission rates, procedure lengths, and estimated blood loss, there were no significant differences between readmission or complication rates. Higher complexity was associated with increased conversion rates. This study indicates that complex cases may safely be performed laparoscopically; however, patient selection and counseling are critical in the choice of operative approach.

Table 1: Univariate Analysis Assessing Outcomes Following Total Laparoscopic Hysterectomy By Complexity Tier

Outcomes	Overall n=1267	Tier 1 n=239	Tier 2 n=674	Tier 3 n=354	P-Value
Readmits (n%)	41 (3.2%)	4 (1.6%)	24 (3.5%)	13 (3.6%)	0.32
Emergency Department Visits (n%)	168 (13.3%)	26 (10.9%)	96 (14.2%)	46 (13.0%)	0.41
Urgent Care Visits (n%)	193 (15.2%)	32 (13.6%)	103 (15.1%)	58 (16.1%)	0.61
Complications (n%)	70 (5.5%)	8 (3.3%)	37 (5.4%)	26 (7.2%)	0.12
Admission (n%)	121 (9.5%)	21 (8.8%)	52 (7.7%)	48 (13.6%)	0.01
Mean Procedure Length (min)	161	132	152	194	<0.001
Mean Estimated Blood Loss (mL)	70	41	60	93	<0.001
Conversion to Open (n%)	14 (1.1%)	1 (0.4%)	3 (0.4%)	10 (2.8%)	0.001

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:** Sarah Simko: Nothing to disclose; Karin Jones: Nothing to disclose; Alireza Abidi: Nothing to disclose; Sung Park: Nothing to disclose.

### 15 Efficacy and safety of institution-wide restrictive blood transfusion protocol in gynecologic surgical patients



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**OBJECTIVES:** The use of restrictive blood transfusion protocols has been well documented in specific patient populations, however there is little data in the field of gynecology. The objective of this study was to compare differences in blood transfusion rates and surgical complications before and after the implementation of a restrictive transfusion protocol. The target population included patients undergoing major abdominal surgery by both gynecologists and gynecologic oncologists at a university hospital.

**MATERIALS AND METHODS:** On July 1, 2018, our institution implemented a restrictive blood transfusion protocol based on the American Association of Blood Banks guidelines, recommending against blood transfusion in hemodynamically stable patients when hemoglobin is above 7g/dL. This study was a quality improvement effort using a quasi-experimental design. Retrospective chart review was completed using an institutional surgical database in combination with the ACS National Surgery Quality Improvement Program to review patients undergoing major abdominal surgery by the gynecology and gynecologic oncology services 18 months prior to and post initiation of the transfusion protocol. Outcomes included number of patients, units transfused, and postoperative complication rates. Complications included operating room takebacks, infections, wound disruptions, pulmonary, renal, CNS, and cardiac complications, as well as DVTs, readmissions, and mortality.

Descriptive statistics were collected. Surgical data, including wound class, route of surgery, pathology, length of surgery, and emergent status were also collected. Transfusion and postoperative complication data were then analyzed. Categorical variables were analyzed using chi-squared and Fisher's exact tests. Continuous variables were analyzed using student t-tests. A clustered analysis was also completed to further examine the significance of surgical complications.

**RESULTS:** A total of 739 patients were included. There were 290 people in the pre-protocol group and 449 patients in the post-protocol group. A similar number of patients received blood transfusions in both groups (9.3% vs. 10.6%  $p=0.57$ ). However, significantly fewer units of blood were given post-protocol initiation (72 units vs. 52 units  $p=0.003$ ). All postoperative complications were not significantly different between groups ( $p > 0.05$ ). When a clustered analysis was done of postoperative complications, the difference was still not significant ( $p > 0.05$ ).

**CONCLUSION:** We analyzed the efficacy and surgical complication rates of an institution-wide restrictive blood transfusion protocol in patients undergoing major abdominal gynecologic surgery for both benign and oncologic indications. The restrictive transfusion protocol was effective in decreasing the number of units of blood transfused without affecting postoperative complication rates in these patients.

### DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:

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### 16 Impact of pain catastrophizing in women undergoing pelvic floor surgery



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**OBJECTIVES:** To compare rates of voiding trial (VT) failure after urogynecologic surgery in women with versus (vs) without pain catastrophizing. Additionally, pelvic floor symptom bother and impact were compared between groups.

**MATERIALS AND METHODS:** Women undergoing urogynecologic surgery 03/2020 to 03/2021, who completed a preoperative pain catastrophizing scale (PCS, score range 0 to 52) were included in this retrospective cohort study. Pain catastrophizing was defined as PCS score  $\geq 30$  preoperatively. Women also completed the Pelvic Floor