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 complication 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

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Overall n=1267</th>
<th>Tier 1 n=239</th>
<th>Tier 2 n=874</th>
<th>Tier 3 n=354</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmits (%)</td>
<td>41 (3.2%)</td>
<td>4 (1.6%)</td>
<td>24 (3.5%)</td>
<td>13 (3.6%)</td>
<td>0.32</td>
</tr>
<tr>
<td>Emergency Department Visits (%)</td>
<td>168 (13.3%)</td>
<td>26 (10.9%)</td>
<td>96 (14.2%)</td>
<td>46 (13.3%)</td>
<td>0.41</td>
</tr>
<tr>
<td>Urgent Care Visits (%)</td>
<td>193 (15.2%)</td>
<td>32 (13.6%)</td>
<td>150 (15.1%)</td>
<td>58 (16.1%)</td>
<td>0.81</td>
</tr>
<tr>
<td>Complications (%)</td>
<td>70 (5.5%)</td>
<td>8 (3.3%)</td>
<td>37 (5.4%)</td>
<td>26 (7.2%)</td>
<td>0.12</td>
</tr>
<tr>
<td>Admission (%)</td>
<td>121 (9.5%)</td>
<td>21 (8.1%)</td>
<td>52 (7.7%)</td>
<td>48 (13.6%)</td>
<td>0.01</td>
</tr>
<tr>
<td>Mean Procedure Length (min)</td>
<td>161</td>
<td>132</td>
<td>152</td>
<td>194</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Mean Estimated Blood Loss (mL)</td>
<td>70</td>
<td>41</td>
<td>60</td>
<td>93</td>
<td>0.001</td>
</tr>
<tr>
<td>Conversion to Open (%)</td>
<td>44 (3.5%)</td>
<td>1 (0.4%)</td>
<td>3 (0.4%)</td>
<td>10 (2.8%)</td>
<td>0.001</td>
</tr>
</tbody>
</table>

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:
Sarah Simko: Nothing to disclose; Karin Jones: Nothing to disclose; Aileen Adibi: 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:
Rachel Mojdehbakhsh: Nothing to disclose; Rana Al-Rubaye: Nothing to disclose; Dandi Huang: Nothing to disclose; Joseph Connor: Nothing to disclose; Ahmed Al-Niaimi: Nothing to disclose.

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 ≥30 preoperatively. Women also completed the Pelvic Floor
Impact Questionnaire Short Form (PFIQ-7) as well as the Pelvic Floor Distress Inventory-20 (PFDI-20). Standardized VT was performed within 24 hours postoperatively. VT failure was defined as inability to void ≥2/3 of an instilled maximum tolerated volume (≤300mL). Chi-Square, Fisher’s exact, ANOVA F, and Kruskal-Wallis tests were performed as indicated. Significance level was set at 0.05.

RESULTS: 106 women were included with mean±SD age of 59±13 years, 93% were white, and mean±SD BMI 28.6±6. 16/106 (15%) had PCS scores ≥30, or pain catastrophizing. There were no differences in baseline POPQ stage, procedures performed (including apical suspension, hysterectomy, and midurethral sling), estimated blood loss and operative time between groups (all p>0.05). Baseline demographics did not differ between women with and without pain catastrophizing except that those with PCS≥30 had higher rates of benzodiazepine use (44 vs 11%, p<0.01) as well as anxiety (56 vs 24%, p=0.01), depression (44 vs 18%, p=0.02), and pain syndromes (25 vs 5%, p=0.02). Additionally, they scored higher on all subscales (urinary, colorectal, and prolapase) of the PFIQ-7 as well as on the PFDI-20 (Table). Women with PCS≥30 were less likely to report stress urinary incontinence preoperatively (38 vs 66%, p=0.03). Failure of first VT did not differ between groups with vs without pain catastrophizing (25 vs 27%, p = 0.8). 4/106 (4%) were unable to pass a VT within 7 days postoperatively. None of these were in the PCS≥30 group. 

CONCLUSION: In women undergoing urogynecologic surgery, pain catastrophizing was not associated with VT failure. The pain catastrophizing group had higher pelvic floor symptom severity and impact scores. The pain catastrophizing scale may be useful in highlighting the individual patient impact from pelvic floor disorders and its complex interplay with concomitant diagnoses. This information may be helpful in characterizing women with pelvic floor disorders.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Characteristics</th>
<th>Total</th>
<th>PCS ≥ 30</th>
<th>PCS &lt; 30</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants, n(%)</td>
<td>106 (100)</td>
<td>16 (15.1)</td>
<td>90 (84.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UQ, median (IQR)</td>
<td>42.9 (14.3-71.4)</td>
<td>81 (64.8-90.5)</td>
<td>33.3 (14.3-57.1)</td>
<td>0.0017</td>
<td></td>
</tr>
<tr>
<td>CRADL, median (IQR)</td>
<td>2.5 (0-24.2)</td>
<td>52.4 (38.1-61.9)</td>
<td>15.5 (5-33.3)</td>
<td>0.0012</td>
<td></td>
</tr>
<tr>
<td>POPQ, median (IQR)</td>
<td>23.8 (6-62.4)</td>
<td>81 (69.5-90.5)</td>
<td>19 (0-38.1)</td>
<td>&lt;0.0001</td>
<td></td>
</tr>
<tr>
<td>PFDI-7, median (IQR)</td>
<td>121.4 (79.2-216.8)</td>
<td>191.3 (108.3-204.9)</td>
<td>112.5 (72.9-161.5)</td>
<td>0.0401</td>
<td></td>
</tr>
</tbody>
</table>

Note: *Kruskal-Wallis test used for Median (IQR) data.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:
Thomas C. Powell: Nothing to disclose; Isuzu Meyer: Nothing to disclose; Kimberly D. Martin: Nothing to disclose; Christine Nguyen: Nothing to disclose; Julia Maier: Nothing to disclose; Holly E. Richter: Bluewind, Data Safety Monitoring Board, Financial Compensation; UpToDate, Author/Editor, Royalties; Renovia, Investigator, Grant Funding; Allergan, Investigator, Grant Funding.

18 Predictors of health-seeking behavior for postpartum sexual dysfunction
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OBJECTIVES: To examine predictors for health-care seeking behavior for postpartum sexual dysfunction (PPSD) within three years after delivery.

MATERIALS AND METHODS: Using the Qualtrics platform we administered electronic surveys to 540 women in Ohio, Pennsylvania, and Michigan evaluating the primary domains of female sexual function before and after birth; additional information collected included demographic characteristics, as well as pregnancy and post-partum related variables such as duration of peripartum complications and duration of breastfeeding. Respondents were stratified into controls, those who did not report sexual dysfunction, those with dysfunction seeking care, and those with dysfunction not seeking care. Chi-squared and multivariate logistic regression analyses were used to evaluate variables associated with seeking care for sexual dysfunction.

RESULTS: 540 women responded to the survey in completion, with 449 (83.1%) reporting some form of PPSD. The most common reported symptom was decreased desire, 64.3%, followed by decreased arousal 56.3%, pelvic pain, 34.1%, and decreased orgasm, 25.5%. Out of these, 56.5% resumed sex within 3 months of birth, 33.9% resumed sex between 4-12 months, and 5.3% resumed sex between 12-24%. The remainder did not resume sex at the time of the survey. Only 72 (16.0%), sought care for sexual dysfunction. Multivariable regression variables associated with care seeking for PPSD were difficulty with perineal healing (aOR=4.53, 95%CI: 1.54-13.38), transfuson after delivery (aOR=3.71, 95%CI: 1.44-9.56), reporting decreased desire (aOR=8.52, 95%CI: 2.72-26.76), bothered by decreased desire (aOR=7.13, 95%CI: 2.65-19.12), current dyspareunia (aOR=3.41, 95%CI: 1.31-8.87), reporting medication or substance abuse as cause of decreased desire (aOR=7.95, 95%CI: 3.63-17.42). Factors associated with decreased probability of seeking care were number of kids under 18 years in the home (aOR=0.61, 95%CI: 0.43-0.88 per child), number of cesarean deliveries (aOR=0.46, 95%CI: 0.29-0.74, per delivery), lower decreased sexual desire index score (aOR=0.57, 95% CI: 0.42-0.78, per 1.0 unit increase).

CONCLUSION: Predictors for health care seeking behaviors for sexual dysfunction after childbirth include not only degree of sexual dysfunction, but perceived bother of dysfunction. Identifiable variables were a difficult or complicated birthing experience. Though a majority of women experience new or worsening sexual dysfunction postpartum, few seek care. This study highlights the need for a more comprehensive and longer term approach to providing postpartum care that addresses sexual dysfunction beyond the traditional six week visit.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:
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18 Ice-pop: ice packs for postoperative pain, a randomized controlled trial
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OBJECTIVES: To evaluate the benefit of ice packs as supplement to standard pain management following laparoscopic hysterectomy.

MATERIALS AND METHODS: This IRB approved randomized control trial was conducted at 2 tertiary care hospitals. Patients undergoing laparoscopic hysterectomy with the minimally invasive gynecologic surgery team were considered for inclusion. Patients with chronic pain, current opioid use ≥1 week, or requiring admission were excluded. Subjects were randomized to receive standardized enhanced recovery after surgery (ERAS) management or standardized ERAS plus ice packs. Ice packs were applied to the abdomen after skin closure in the operating room. Pain was assessed using Visual Analogue Scale (VAS). Narcotic requirement was assessed using morphine milligram equivalent (MME).