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 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 prolapse) of the PFIQ-7 as well as 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.

Disclosure of Relevant Financial Relationships:

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: 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, 56.3% 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), transfusion 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.

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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).