two steps: fibroid enucleation and hysterotomy repair. Construct validity was assessed by comparing expert and novice performances on the simulation task. Video recordings were scored by two blinded reviewers using the Global Operative Assessment of Laparoscopic Skills (GOALS) scale (5-20 points) and a modified GOALS scale (5-35 points), incorporating three novel domains specific to laparoscopic myomectomy. The Mann Whitney U test was used to compare task completion times and performance scores. Interrater reliability of scoring was assessed using the interclass correlation coefficient (ICC). Face validity was assessed with a post-task survey regarding the model’s realism, utility, and educational effect.

RESULTS: A 3:1 ratio was used to recruit 15 novices and 5 experts. Median time to task completion was shorter for experts compared to novices (11.8 vs. 20.1 minutes, \( P = .004 \)). Experts scored higher than novices on both the GOALS scale (median 19 [range 13-20] vs. 10 [6-17.5], \( P = .007 \)) and modified GOALS scale (31.5 [21.5-33.5] vs. 18.5 [13.5-32], \( P = .009 \)). The ICC was 0.95 for the GOALS scores and 0.96 for the modified GOALS scores. The majority of participants agreed that the model closely approximated the feel of fibroid enucleation (70%) and suturing the uterus (80%). All participants agreed that the model was useful for learning or teaching laparoscopic myomectomy.

CONCLUSION: This study demonstrates validity for a novel, low-cost laparoscopic myomectomy model and a novel assessment scale for laparoscopic myomectomy. This simulation model provides a targeted training tool for laparoscopic myomectomy, with a focus on unique steps of the procedure.

Performance on Simulation Model

<table>
<thead>
<tr>
<th>Performance Metrics</th>
<th>Experts (n=5)</th>
<th>Novices (n=15)</th>
<th>( P )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Time (min)</td>
<td>11.8 (2-18.5)</td>
<td>20.1 (12.4-30.5)</td>
<td>.004</td>
</tr>
<tr>
<td>Time, Part 1- Enucleation (min)</td>
<td>2.7 (2-6.5)</td>
<td>4.5 (1-9.9)</td>
<td>.097</td>
</tr>
<tr>
<td>Time, Part 2- Suturing (min)</td>
<td>7.8 (6-14.4)</td>
<td>16.1 (8.6-30.0)</td>
<td>.002</td>
</tr>
<tr>
<td>Total GOALS score</td>
<td>19 (13-20)</td>
<td>10 (6-17.5)</td>
<td>.007</td>
</tr>
<tr>
<td>Depth perception</td>
<td>4.5 (3-5)</td>
<td>3 (1-5.4)</td>
<td>.007</td>
</tr>
<tr>
<td>Bimanual dexterity</td>
<td>4.5 (3-5)</td>
<td>3 (1-5.4)</td>
<td>.014</td>
</tr>
<tr>
<td>Efficiency</td>
<td>4.5 (3-5)</td>
<td>2 (1-4.5)</td>
<td>.006</td>
</tr>
<tr>
<td>Tissue handling</td>
<td>5 (4-6)</td>
<td>3 (1-5.4)</td>
<td>.003</td>
</tr>
<tr>
<td>Total modified GOALS score</td>
<td>31.5 [21.5-33.5]</td>
<td>18.5 [13.5-32]</td>
<td>.007</td>
</tr>
<tr>
<td>Fibroid dissection/enucleation</td>
<td>4.5 (3-5)</td>
<td>3 (2-6)</td>
<td>.027</td>
</tr>
<tr>
<td>Needle handling</td>
<td>5 (2-5.5)</td>
<td>3 (1-5.5)</td>
<td>.027</td>
</tr>
<tr>
<td>Two-layer uterine closure</td>
<td>3.5 (3-5)</td>
<td>3 (1-4.5)</td>
<td>.013</td>
</tr>
</tbody>
</table>

GOALS, Global Operative Assessment of Laparoscopic Skills Data reported as median (range) *Modified GOALS score includes GOALS metrics with addition of the three listed novel metrics

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Rebecca Schneyer: Nothing to disclose; Andrea Molina: Nothing to disclose; Isabel Green: Intuitive Surgical, Grant recipient, Non restricted medical education grant; Stacey A. Scheib: Myovant, Membership on advisory board, Honorarium; UpToDate, Contributor; Royalties; Kristin Mara: Nothing to disclose; Matthew T. Siedhoff: Applied Medical, Consultant, Consulting fee; Kelly Wright: Aqua Therapeutics, Consultant, Consulting fee; Hologic, Consultant, Consulting fee; Karl Storz, Consultant, Consulting fee; Mireille D. Truong: Ethicon, Consultant, Consulting fee; Medtronic, Consultant, Consulting fee.

08 Changes in sexual function over 12 months after native-tissue vaginal organ prolapse surgery with and without hysterectomy

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OBJECTIVES: The objective of this study was to determine changes in sexual function in both sexually active and non-sexually active women after native-tissue pelvic organ prolapse surgery. The secondary objectives were to determine predictors for post-operative dyspareunia and to compare post-operative sexual function between hysteropexy and post-hysterectomy colpopexy versus prolapse procedures with concurrent hysterectomy.

MATERIALS AND METHODS: This was a planned secondary analysis of a prospective cohort study evaluating the impact of the intraoperative resting genital hiatus size on prolapse recurrence. Sexual function was evaluated at baseline, 6 and 12 months post-operatively using the Pelvic Organ Prolapse-Urinary Incontinence Sexual Function Questionnaire — IUGA Revised instrument (PISQ-IR) with a Minimal Clinically Important Difference (MCID) set at 0.31. Variables of interest for regression analysis assessing predictors for dyspareunia included patient characteristics, peroperative data including intra- and postoperative genital hiatus size. To examine the impact of hysterectomy and uterine-preservation on sexual function, the following groups were compared: concurrent hysterectomy vs no hysterectomy.
hysterectomy [post-hysterectomy colpopexy and hysteropyexy] and concurrent hysterectomy vs hysteropyexy.

**RESULTS:** 59 patients underwent prolapse surgery with follow-up at 12 months (hysterectomy N=28, 47.5%, non-hysterectomy N=31, 52.5%, hysteropyexy N= 17, 28.8%). There was improved sexual function for all patients at 6 and 12 months post-operatively (p-value 0.008 and 0.001, respectively) (Table 1). The proportion of sexually active patients increased from 43.9% preoperatively to 53.7% postoperatively. Stratified by sexual activity, sexually active patients had significant improvement in sexual function (+0.38 [-0.05, 0.71], p=0.005) at 12 months exceeding the MCID; no statistically significant improvement was seen in non-sexually active patients. The incidence of de novo dyspareunia decreased from 16.2% at 6 months to 8.1% at 12 months (p=0.08) for all patients. On univariate analysis, no variables were associated with dyspareunia. At 12 months, there was no difference in the PISQ-IR score in patients who underwent a hysteropyexy compared to hysterectomy (p=0.24), and no difference between non-hysterectomy and the hysterectomy group (p=0.61). There were no differences in post-operative dyspareunia or de novo dyspareunia after hysteropyexy compared to the hysterectomy group (p=0.99).

**CONCLUSION:** At 12 months, there was a statistically significant and clinically meaningful improvement in sexual function after all types of native-tissue pelvic organ prolapse surgery in sexually active women. There was no difference in sexual function in patients undergoing hysteropyexy or post-hysterectomy colpopexy compared to patients undergoing apical prolapse surgery with concurrent hysterectomy.

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**
Olivia H. Chang: Nothing to disclose; Meng Yao: Nothing to disclose; Cecile Ferrando: Nothing to disclose; Marie Fidelia R. Parsons: Nothing to disclose; Robert E. Gutman: Nothing to disclose; Michele Torosis: Nothing to disclose; Kasey Roberts: Nothing to disclose; Katherine L. Woodburn: Nothing to disclose; Angela Yuan: Nothing to disclose.

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**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**
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**OBJECTIVES:** To compare anatomic failure, prolapse symptoms, retreatment and incidence of peri-operative adverse events between patients undergoing vaginal uterosacral hysteropyexy (USHP) and sacropinous hysteropyexy (SSHP).

**MATERIALS AND METHODS:** This was a multi-center retrospective cohort study of patients who underwent USHP or SSHP with a FPMRS surgeon between 2015 and 2019. Patients were excluded if they had no follow up greater than 6 weeks postoperatively. Anatomic failure was defined as prolapse beyond the hymen. Composite failure was defined as anatomic failure, bulge symptoms, and/or re-treatment for prolapse.

**RESULTS:** At 4 sites, 147 patients underwent SSHP and 114 underwent USHP. SSHP patients were younger (62±13 vs 58±13 yrs, p=0.01) and had a higher BMI (28 vs 26 kg/m², p=0.002) otherwise there were no differences in characteristics between groups. USHP patients were more likely to undergo concurrent anterior repair (86% vs 70%, p=0.002), posterior repair (84% vs 65%, p=0.001) and incontinence procedures (52% vs 38%, p=0.033). Operative time was longer in the USHP group (125 (105, 160) vs 91 (70, 118) min, p<0.001). 49% of USHP utilized permanent or permanent and delayed absorbable sutures while 82% of SSHP were performed with delayed absorbable sutures (p<0.001).

The 6-week follow up rate was 95% (138 SSHP and 111 USHP patients), at which time there were 4 (1.5%) anatomic failures: 1 (0.7%) SSHP and 3 (2.6%) USHP (p=0.321) while 25 patients (9.9%) reported bulge symptoms (10%SSHP vs 9.8%USHP) and none underwent retreatment. At 12 months, the follow up rate was 32% (83/261) with no difference between groups. There were 10 (3.8%) anatomic failures: 3 (2%) SSHP and 7 (6.1%) USHP (p=0.109).

There was no difference in bulge symptoms(10%), composite failure(13%) or median POP stage (2).

Only 8 SSHP and 2 USHP patients had cervical elongation. 50% of the SSHP patients without trachelectomy required surgical retreatment. Of the 4 SSHP patients who underwent trachelectomy, none had retreatment for prolapse though 1 reported bulge symptoms. No USHP patients underwent partial trachelectomy or retreatment for prolapse but 1 patient had anatomic and symptomatic failure.

The overall incidence of complications was low (7%) with a higher rate of ureteral kinking in the USHP group (7% vs 1.4%, p=0.023).

With median follow up of 17 months, 12 patients (4.6%) underwent subsequent hysterectomy, 11 of which were for recurrent prolapse, with no difference between the groups (6.8%SSHP vs 1.8% USHP, p=0.073). Additionally, 17 patients (6.5%) underwent treatment for uterine/cervical pathology (12 SSHP vs 5 USHP, p=0.313)

**CONCLUSION:** One year after hysteropyexy, 1 in 3 patients were available for follow-up and there were no differences in prolapse recurrence between patients who underwent USHP versus SSHP. The incidence of adverse events was low and less than 5% of patients underwent subsequent hysterectomy for prolapse.

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**
Katherine L. Woodburn: Nothing to disclose; Angela Yuan: Nothing to disclose; Michele Torosis: Nothing to disclose; Kasey Roberts: Nothing to disclose; Robert E. Gutman: Boston Scientific, Consultant, Grant funding, consulting fees; Johnson and Johnson, Expert witness, Honorarium.

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