undergoing apical prolapse surgery with concurrent hysterectomy.

**RESULTS:** 59 patients underwent prolapse surgery with follow-up at 12 months (hysterectomy N=28, 47.5%, non-hysterectomy N=31, 52.5%, hysteropexy 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 hysteropexy compared to hysterectomy (p=0.24), and no difference between non-hysterectomy and the hysterectomy group (p=0.61). There were no differences in postoperative dyspareunia or de novo dyspareunia after hysteropexy 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 hysteropexy or post-hysterectomy colpopexy compared to patients undergoing apical prolapse surgery with concurrent hysterectomy.

**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 hysteropexy (USHP) and sacropinous hysteropexy (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 1 year, 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 tracheectomy required surgical retreatment. Of the 4 SSHP patients who underwent tracheectomy, none had retreatment for prolapse though 1 reported bulge symptoms. No USHP patients underwent partial tracheectomy 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 hysteropexy, 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.

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