compared to patients undergoing POP-surgery alone. Combined patients also had a similar risk of recurrent POP and subsequent POP surgery compared to patients undergoing POP-only surgery.

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**
Shannon L. Wallace: Nothing to disclose; Youngwu Kim: Nothing to disclose; Erica Lai: Nothing to disclose; Shailja Mehta: Nothing to disclose; Bertille Gaigbe-Togbe: Nothing to disclose; Chiyuan Amy Zhang: Nothing to disclose; Emily C. Von Bargen: Nothing to disclose; Eric R. Sokol: Nothing to disclose.

**15 “I’m not going home with a catheter”: patient-centered outcomes associated with peri-operative intermittent catheterization**
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**OBJECTIVES:** Impaired bladder emptying after surgery is often managed with an indwelling catheter, which can be a source of dissatisfaction, infection, and burden. Intermittent straight catheterization (ISC) is an alternative, though it is less well studied. This study describes patient satisfaction and outcomes associated with planned ISC after outpatient pelvic reconstructive surgery.

**MATERIALS AND METHODS:** This was an ancillary analysis of a prospective cohort study at an academic tertiary referral center from September 2018-June 2021. Participants completed pre-operative ISC teaching that included an instructional video (SGS; A Guide to Female Clean Intermittent Catheterization, 6:20 minutes), 1:1 teaching with an RN or MD, and provision of ISC supplies. After surgery, participants were instructed to ISC until they had 2 consecutive outpatient PVRs < 1/2 voided volume. Demographic information was self-reported, clinical information was abstracted from the medical record, and patient satisfaction was assessed 2 weeks post-procedure.

**RESULTS:** For the 158 participants, mean age was 51.9 ±11.3 years, mean BMI was 28.9 ±5.8 kg/m2, with 140/155 (90.3%) identifying as white and 18/155 (11.6%) as Hispanic. Average provider time-investment in ISC teaching was 9.8 ±5.6 minutes. Providers performing ISC teaching subjectively noted “some” difficulty with ISC for 21/158 (13.3%) participants, “minimal” difficulty for 15/158 (9.5%), and “no” difficulty for 122/158 (77.2%). Mean time from ISC teaching to surgery was 16.3 ±15.6 days. Mean duration of surgery was 43.4 ±28.3 minutes. The average number of outpatient ISC was 4.9 ±5.7. Median time to achievement of 2 PVRs < 1/2 voided volume was 6.3 hours (95% CI 5.8-8.6). One-hundred forty-one participants (141/158, 89.2%) performed ≥1 ISC post-operatively, with difficulties noted in Table 1. Most participants reported satisfaction on 2-week follow-up (Figures 1 and 2). Difficulty performing ISC was not associated with time since ISC teaching (p=0.29) or difficulty noted at ISC teaching by the provider (p=0.25). On multiple logistic regression, age, BMI, and prolapse beyond the hymen did not predict difficulty learning or performing ISC. Between ISC teaching and 6 weeks post-procedure, 23/158 (14.6%) participants endorsed symptoms of a urinary tract infection (UTI), 16/158 (10.1%) had a culture-proven UTI, 2/16 (12.5%) of which were diagnosed pre-operatively.

**CONCLUSION:** Some women undergoing pelvic reconstructive surgery report ease and satisfaction with ISC. This was not limited by age, BMI, prolapse stage, or provider-perceived difficulty learning ISC.

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**
Julia Shinnick: Nothing to disclose; Christina A. Raker: Nothing to disclose; Charles Rardin: Nothing to disclose; Elizabeth J. Geller: Nothing to disclose; Anne C. Cooper: Nothing to disclose.

**16 Return to work following pelvic reconstructive surgery: secondary analysis of operations and pelvic muscle training in the management of apical support loss (optimal)**
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**OBJECTIVES:** To evaluate patients’ return to work and loss of productivity following pelvic reconstructive surgery.

**MATERIALS AND METHODS:** This is a secondary analysis of the Operations and Pelvic Muscle Training in the Management of Apical Support Loss (OPTIMAL) trial. The primary outcome is number of work days missed following surgery. Loss of productivity included hours worked per week and discontinuation of paid work. Predictors affecting the timing of return to work were assessed.

**RESULTS:** In the trial, 180 (49%) of patients worked at baseline reporting 35±13 hours per week. The median number of days missed following
surgery was 35 (range 0–210 days). Among these, 21 (13%) did not miss any work days, 43 (27%) missed two weeks or less, and 130 (81%) missed 6 weeks or less. Return to work did not differ between patients who underwent sacrospinous ligament fixation (SSLF) vs. uterosacral ligament suspension (USLS) (P=0.23) (Figure 1). At 3 months, 15 (9%) of patients who were working before surgery had stopped working, and 17 (11%) of patients who were working reported being about 40% less productive for a median of 4 days per month. Most patients (96%) reported not missing any hours of housework by 3 months. Comparing patients who missed ≥6 weeks, those who missed <6 weeks had a higher rate of retreatment with pessary/surgery within 2 years (6.8% vs. 0%, P=0.03) (Table 1). Comparing patients who missed <2 weeks to ≥2 weeks, the former worked 6–8 fewer hours prior to and following surgery (P values <0.05), were less likely to have private insurance (77% vs. 91%, P=0.03), and had a higher rate of retreatment (13% vs. 1.7%, P=0.007).

CONCLUSION: Half of patients returned to work <5 weeks following pelvic reconstructive surgery. There was no difference between those who underwent USLS vs. SSLF. Working less than full time and not having private insurance were predictors of earlier return to work, and those who underwent USLS had higher rates of retreatment.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Rui Wang: Nothing to disclose; Elisabeth C. Sappenfield: Nothing to disclose.

17 Whose outcomes are we measuring? review of patient-reported outcome study populations
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OBJECTIVES: In 2020, the Pelvic Floor Disorders Consortium Working Group on Patient-Reported Outcomes evaluated patient-reported outcome (PRO) instruments in pelvic floor disorders. PROs measure patients’ lived experiences and are considered appropriate for use in populations where their validity properties have been evaluated. The social construct of race can impact lived experience. It is unclear if this is accounted for in existing PROs. This study describes the race and ethnicity characteristics of the validation study populations in cited PRO instruments.

MATERIALS AND METHODS: Review of studies considered in “Measuring Pelvic Floor Disorder Symptoms Using Patient-Reported Instruments: Proceedings of the Consensus Meeting of the Pelvic Floor Consortium of the American Society of Colon and Rectal Surgeons, the International Continence Society, the American Urogynecologic Society, and the Society of Urodynamics, Female Pelvic Medicine and Urogynecological Re却结构.” Dates, locations, and participant race, ethnicity, and gender information was abstracted. Racial and ethnic representation was compared to census data for US-based studies. The primary outcome was the representation quotient of reported races and ethnicities, calculated as the reported percentage of the study population identifying with a race and/or ethnicity divided by the proportion of the US population identifying with that race and/or ethnicity during the study period.

RESULTS: Forty-four studies with 21,035 participants were included. Mean age was 51 ±8.4 years, with 13,957/21,035 (66.4%) female participants. Race was reported in 16/44 (36.4%) studies and ethnicity reported in 7/44 (15.9%). Studies did not specify how this information was collected, though 75.5% (10,011/13,263) of participants were reported as white and 8.7% (792/9,066) as Hispanic. For US-based studies, the representation quotient of white participants from 1995–2019 was 1.13, indicating overrepresentation, which did not change over time (Table 1). Indigenous American/Native American/American Indian/Alaska Natives had the lowest representation quotient (0.24; Figure 1). There was a trend toward increased reporting of ethnicity (p=0.001), but not race (p=0.06).

CONCLUSION: White patients may be over-represented in US-based validation studies for PRO instruments in pelvic floor disorders. Consideration should be given to whether these instruments appropriately capture the experiences of non-white populations.