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 returned to work earlier had higher rates of retreatment.

Figure 1. Distributions of days of work missed following surgery for patients who underwent uterosacral ligament suspension (USLS) compared to sacrospinous ligament fixation (SSLF) and worked prior to surgery.

Table 1. Patient characteristics among those who missed <2 or 6 weeks compared to those who missed ≥2 or 6 weeks.

	Missed less than 2 weeks (N=30)	Missed 2 weeks or more (N=131)	P value	Missed less than 6 weeks (N=85)	Missed 6 weeks or more (N=76)	P value
Prior to surgery						
Hours worked per week	30 ± 15	36 ± 12	0.013	34 ± 14	37 ± 11	0.205
Days per month less productive	10 ± 9.9	8.5 ± 7.8	0.544	6.5 ± 7.1	11 ± 8.3	0.033
3 months following surgery						
Hours worked per week	28 ± 15	36 ± 12	0.009	34 ± 15	36 ± 11	0.375
Days per month less productive	-	5.7 ± 3.9	-	6.0 ± 3.9	5.5 ± 4.1	0.816
24 months following surgery						
Hours worked per week	31 ± 11	38 ± 13	0.035	36 ± 13	39 ± 12	0.158
Days per month less productive	-	9.4 ± 7.3	-	12 ± 12	8.0 ± 5.3	0.671
Anatomic failure at 24 months*	5 (22)	22 (19)	0.759	15 (21)	12 (18)	0.663
Retreatment at 24 months**	3 (13)	2 (1.7)	0.007	5 (6.8)	0 (0)	0.032
Any bothersome bulge at 24 months	6 (27)	20 (18)	0.317	16 (23)	10 (16)	0.353

Data shown as median (IQR), mean ± SD, or N (%). *Defined as descent beyond the hymen
**Defined as pessary or surgery 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 Urogenital Reconstruction.*" 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.

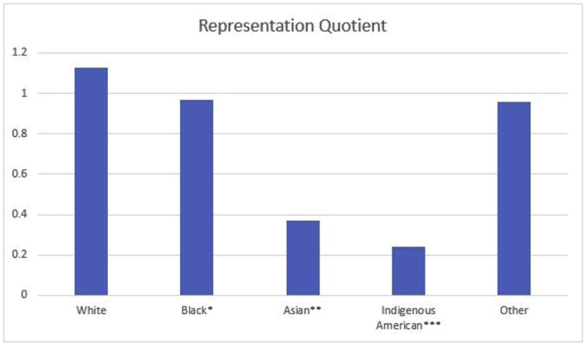

Figure 1. Representation quotient of reported races compared to the United States population. Calculated as the percent of each race reported in the United States-based studies that reported race, divided by the percentage of the United States population that identified with that race during the years of the study, according to United States census data. *race reported as Black, African American, or African; **race reported as Asian or Pacific Islander; ***race reported as Indigenous American, Native American, American Indian, or Alaska Native

Trends in Inclusion of Reported Races Over Time

Representation Quotient	1995-1999	2000-2004	2005-2009	2010-2014	2015-2019	Correlation
White	1.26	1.14	1.39	1.11	1.10	-0.45 p=0.45
Black*	0	1.09	0	0.95	1.09	0.56 p=0.32
Asian**	0	0.13	0	1.15	0.14	0.42
						p=0.48
Indigenous American***	0	0.08	0	0	0.44	0.66 p=0.22
Other	1.83	0.78	0	0.61	1.18	-0.34 p=0.57

*Black, African American, or African **Asian or Pacific Islander ***Indigenous American, Native American, American Indian, or Alaska Native

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Julia Shinnick: Nothing to disclose; Moiuri Siddique: Nothing to disclose; Spandana Jarmale: Nothing to disclose; Christina A. Raker: Nothing to disclose; Vivian Sung: Nothing to disclose; Cassandra Carberry: Nothing to disclose.

18 Can fpmrs fellows meet the minimum number of midurethral sling and burch urethropexy procedures to graduate? — a review of the national trend using the national surgical quality improvement program database from 2009 to 2019

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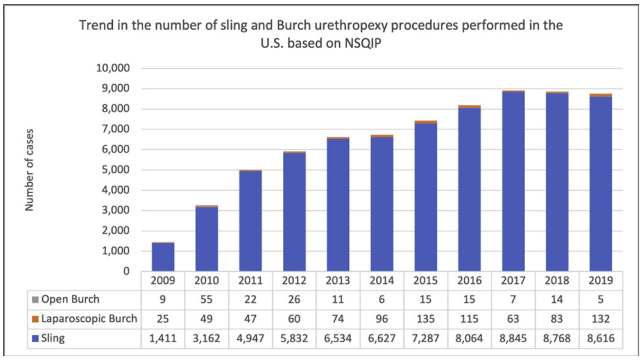
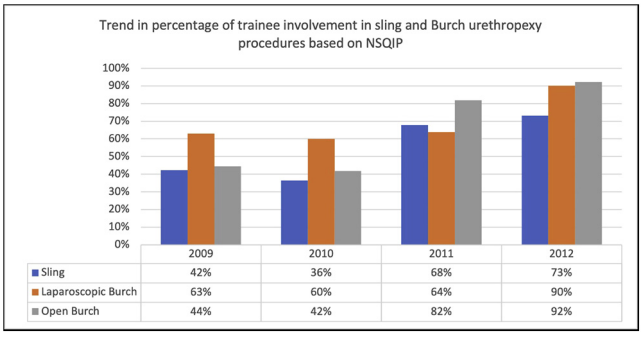
OBJECTIVES: The Accreditation Council for Graduate Medical Education (ACGME) requires 50 midurethral sling (either synthetic mesh or fascial), and 5 Burch urethropexy procedures to graduate from Female Pelvic Medicine and Reconstructive Surgery (FPMRS) fellowship. Given that there are now as many as FPMRS 160 fellows at 64 accredited programs, there should be at least 2,667 sling and 267 Burch urethropexy procedures performed nationally and annually to meet this requirement. The primary aim of this study was to review the annual trend in the number of sling and Burch procedures performed using the National Surgical Quality Improvement Program database that captures 700 institutions including 54 of the 64 FPMRS fellowship programs. The secondary aim was to review the trend in trainee involvement in these cases.

MATERIALS AND METHODS: This was a retrospective cohort study using the NSQIP database. Of note, because NSQIP does not capture office procedures, periurethral injection procedure that is primarily performed in the office was not included in this study. We identified all female patients who underwent sling, laparoscopic Burch and open Burch between 2009 and 2019 using Current Procedural Terminology (CPT) codes. Variable coding the presence or absence of trainee involvement was only available from 2009 to 2012. Findings are described using proportions.

RESULTS: On average, 6,372 sling and 97 Burch (either laparoscopic or open) urethropexy procedures were performed annually during the study period. Proportion of cases with trainee involvement ranged from 46% to 78% with an increase over the years.

CONCLUSION: Our findings suggest that the minimum number of Burch urethropexy procedures to graduate from FPMRS fellowship may be unfeasible to achieve even with an increasing rate of trainee involvement. A change in the educational paradigm may be necessary to train all FPMRS fellows to competently perform Burch urethropexy independently.





DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Edward K. Kim: Nothing to disclose; Christopher X. Hong: COSM Medical Corp., Toronto, ON, Canada, Co-author, Consultant; Heidi S. Harvie: Nothing to disclose.

19 Impact of intrarectal diazepam on early postoperative pain following pelvic reconstructive surgery: a double-blind, randomized placebo-controlled trial

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OBJECTIVES: To evaluate the effect of diazepam rectal suppositories on early postoperative pain following hysterectomy and vaginal reconstruction for pelvic organ prolapse.

MATERIALS AND METHODS: In this institutional review board approved, double-blind, randomized placebo-controlled trial, eligible patients were those scheduled to undergo a total vaginal hysterectomy with