

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.

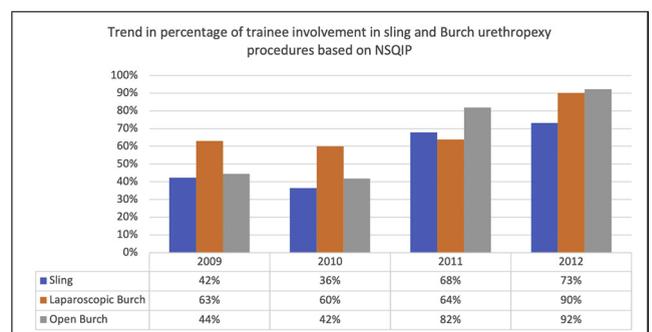
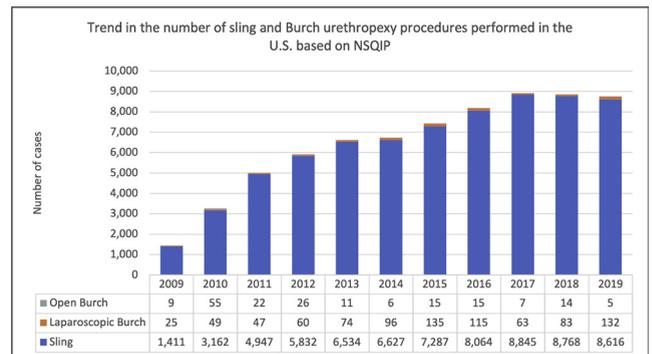
**MATERIALS AND METHODS:** This was a retrospective cohort study using the NSQIP database. Of note, because NSQIP does not capture office procedures, periurethral injection procedure that is primarily performed in the office was not included in this study. We identified



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



reconstructive surgery for prolapse. Consented patients were randomized to receive either a 10mg diazepam rectal suppository or an identical appearing placebo intraoperatively at the completion of surgery. Our primary outcome was vaginal pain 3.5-6 hours postoperatively utilizing the 100mm visual analog scale (VAS). Participants also completed surveys regarding pain at baseline, the morning of postoperative day (POD) one, and two-weeks postoperatively. Secondary outcomes included total morphine equivalents following surgery, patient satisfaction with pain control, and overall satisfaction. Chi-squared test, Fisher's exact test, and Mann-Whitney test were utilized. Our sample size calculation demonstrated that 55 patients per arm were required to detect a difference in our primary outcome.

**RESULTS:** From February 2020 to August 2021, 130 subjects were randomized. Seven patients withdrew, 113 have been analyzed to date; 57 in the diazepam group, 56 in placebo. The median age was 65 (IQR 27, 80), median BMI was 27.9 (IQR 18.70, 45.90), and 96.5% (n=109) of participants were white. There were no differences in baseline characteristics, prolapse stage, or types of procedures performed between groups. Ninety-nine percent (n=112) of participants had concurrent uterosacral ligament suspension, anterior and posterior repairs. Forty-one percent (n=46) had mid-urethral slings. Forty-five percent (n=51) had same-day discharge. There were no differences in the amount of intraoperative lidocaine injected (30.84 vs 30.16mL, p=0.679) or amount of rescue narcotics used in the immediate postoperative period (22.5 vs 16 morphine equivalents, p=0.286). There was also no difference in the primary outcome of VAS score for vaginal pain 3.5-6 hours postoperatively (24 vs 21mm, p=0.417). At their 2-week survey, patients in the placebo group reported higher satisfaction with pain control in the hospital (31 vs 41mm, p=0.012) and pain control at home (31 vs 40mm, p=0.043). No differences were noted among patients discharged on POD0 compared to those admitted overnight.

**CONCLUSION:** In our population, placement of a 10mg Diazepam rectal suppository immediately following pelvic reconstructive surgery did not improve pain or narcotic usage in the early postoperative period. Although the placebo group reported slightly higher satisfaction with pain control two-weeks following surgery, overall pain levels were low. Therefore, we do not feel the addition of diazepam to the post-operative regimen is warranted.

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**

Emily R. Aldrich: Nothing to disclose; Tiffanie Tam: Nothing to disclose; Leah Saylor: Nothing to disclose; Catrina C. Crisp: Nothing to disclose; Jennifer Yeung: Nothing to disclose; Eunsun Yook: Nothing to disclose; Rachel N. Pauls: Nothing to disclose.

**20 Non-white women are more likely to have open hysterectomies after controlling for geographic variations in a nationally representative cross-sectional study using hcup**



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**OBJECTIVES:** To evaluate the differences in surgical approaches to hysterectomy by race and ethnicity using a nationally representative sample inclusive of all payers and patient encounters that accounts for geographic differences.

**MATERIALS AND METHODS:** This cross-sectional study uses the Healthcare Cost and Utilization Project National Inpatient Sample, a comprehensive national database of inpatient encounters that includes all payers and includes a demographically and geographically representative sample within the United States. Race and ethnicity

are patient reported. Abdominal, laparoscopic, and vaginal hysterectomies are identified using procedural codes. Differences in rates of open versus minimally invasive hysterectomies are analyzed by racial groups and adjusted for potential confounders including geographic regions.

**RESULTS:** In 2017, 35,865 patients underwent hysterectomy in this nationally representative sample, with 18,943 (55%) White, 7,472 (22%) Black, 5,244 (15%) Hispanic, 1,472 (4.2%) Asian, 165 (0.5%) Native American, and 1,390 (4.0%) other races. Overall, 72% of patients underwent abdominal hysterectomy, with the highest rate in Black women (83%, P<0.001); 12% of patients underwent laparoscopic hysterectomy, with the lowest rate in Black women (8.2%, P<0.001); and 6.9% of patients underwent vaginal hysterectomy, with the lowest rate in Black women (3.1%, P<0.001). These differences remained after controlling for patient characteristics, comorbidity, hospital characteristics, census divisions, metropolitan areas, and payers: Black (aOR 1.9, 95% CI 1.8-2.1, P<0.001), Hispanic (aOR 1.1, 95% CI 1.0-1.2, P=0.01), and Asian (aOR 1.7, 95% CI 1.5-2.0) women were more likely to have abdominal hysterectomies. Black race remained a significant predictor of abdominal hysterectomy in the multivariate analysis even among patients with a diagnosis of prolapse (adjusted OR 1.6, 95% CI 1.2-2.1, P=0.001).

**CONCLUSION:** Black, Hispanic, and Asian women had higher rates of open abdominal hysterectomy and lower rates of laparoscopic hysterectomy in a nationally representative sample controlling for not only patient characteristics, but also potential biases in practice patterns across geographic areas, payers, and hospital factors.

Table 1. Multivariate logistic regression\*

	Adjusted Odds Ratio (aOR)	95% Confidence Interval (CI)	P value	aOR	95% CI	P value	aOR	95% CI	P value
	Abdominal hysterectomy (N=25,048)			Laparoscopic hysterectomy (N=4,096)			Vaginal hysterectomy (N=2,396)		
	Race (patient reported)								
White	1 (reference)			1 (reference)			1 (reference)		
Black	1.95	1.81-2.10	<0.001	0.56	0.51-0.61	<0.001	0.52	0.44-0.60	<0.001
Hispanic	1.10	1.02-1.19	0.013	0.76	0.70-0.83	<0.001	1.39	1.23-1.57	<0.001
Asian	1.72	1.51-1.96	<0.001	0.61	0.53-0.71	<0.001	0.67	0.53-0.85	0.001
Native American	1.13	0.78-1.65	0.511	0.93	0.62-1.39	0.720	0.81	0.39-1.68	0.574
Other race	0.99	0.87-1.12	0.847	0.96	0.84-1.10	0.572	1.15	0.93-1.42	0.195

\*Adjusted for age, mortality risk, morbidity risk, median household income, hospital bed size, teaching status, hospital ownership, payer source, metropolitan area, and census division

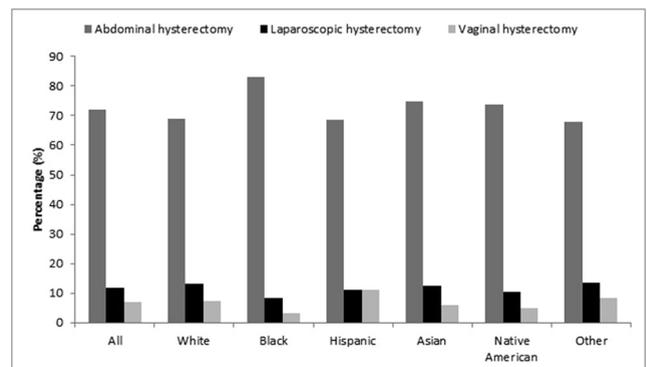


Figure 1. Rates of abdominal, laparoscopic, and vaginal hysterectomies by patient reported race

**DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:**

Rui Wang: Nothing to disclose; Elena Tunitsky: Nothing to disclose.