

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:**

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**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

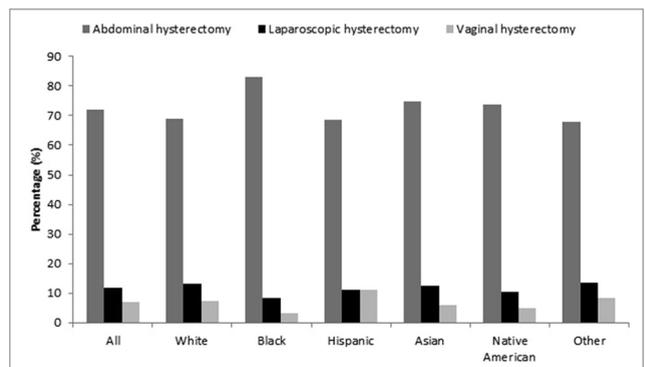


Figure 1. Rates of abdominal, laparoscopic, and vaginal hysterectomies by patient reported race

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