Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

CONCLUSION: The last decade has seen increased SDD among all forms of MIH, which was associated with significant reductions in readmission rates and major and minor complication. Moreover, there were no temporal trends noted within the analysis period, suggesting that the observed outcomes are not entirely attributable to selection bias among those offered SDD. These data suggest that SDD may have advantages over inpatient admission after MIH and can be safely expanded to a larger portion of individuals undergoing MIH.

Table 1. Odds of 30-day postoperative outcomes among those who were discharged same day following minimally invasive hysterectomy.

	Unadjusted OR	95% CI		Adjusted OR	95% CI	
Readmission	0.759	0.686	0.84	0.755	0.681	0.836
Clavien-Dindo III-V Complications	0.754	0.688	0.827	0.741	0.674	0.814
Clavien-Dindo I-II Complications	0.774	0.717	0.835	0.782	0.724	0.845
Superficial SSI	0.836	0.816	0.977	0.852	0.731	0.993
Any SSI	0.749	0.65	0.864	0.754	0.652	0.872
UTI	0.886	0.806	0.972	0.911	0.828	1.003

Model adjusted for age, body mass index, race/ethnicity, American Society of Anesthesiologists class, hypertension requiring medication, smoking within the last years, NSQIP functional status, presence of any major medical comorbidity, and uterine size.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Douglas Luchristt: Nothing to disclose; Kimberly Kenton: Nothing to disclose; C E. Bretschneider: Nothing to disclose.

26 Risk of obstetric anal sphincter injury by delivering provider type

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OBJECTIVES: Obstetric anal sphincter injuries (OASIs) have significant short- and long-term effects including pain, anal incontinence, and sexual dysfunction. OASI is one of the few modifiable risk factors for anal incontinence, yet OASI complicate at least 8% of vaginal deliveries. There is a paucity of data examining delivering provider type as a risk factor. Our objective was to assess if the primary delivering provider, certified nurse-midwife versus physician obstetrician, is associated with OASI. We hypothesized more OASIs with midwives as the delivering provider.

MATERIALS AND METHODS: This was a secondary analysis of a multicenter, retrospective cohort study from the *Consortium of Safe Labor*. Included were nulliparous women who had a vaginal delivery of a singleton fetus at >37 weeks gestational age from 2002 to 2008. Women were excluded if delivery was complicated by shoulder dystocia or from sites without deliveries. Student t-tests, chi-squared analysis, and Fisher's exact test were used as appropriate to assess baseline characteristics, labor factors, and OASIs. Multivariable logistic regression and propensity score matching analyses were performed to control for characteristics associated with OASI. Data are presented as adjusted odds ratio (aOR).

RESULTS: Of 228,668 births at 19 sites, a total of 2,735 births from 3 sites met inclusion criteria: 1,551 physician and 1,184 midwife births. Of all births, 4.24% (n = 116) were complicated by OASI. Physician patients were older (23 ± 5 vs 21 ± 4 years), there were more White patients (26.4% vs 14.3%), privately insured (39.1% vs 22.8%), with higher pre-pregnancy BMI (25.5 ± 6.4 vs 24.8 ± 5.8 kg/m^2), more medical co-morbidities, labor inductions (40.9% vs 20.4%), labor augmentations (28.2% vs 16.2%), and episiotomies (15.5% vs 5.2%; *all* $P < 0.05$). Midwife patients had higher fetal gestational age (39.7 ± 1.1 vs 39.4 ± 1.2 weeks) and infant birth weights (3.3 ± 0.4 vs 3.2 ± 0.4 kg; *all* $P < 0.05$). OASIs were more common in physician compared to midwife births (5.9% vs 2.0%, $P < 0.0001$). This difference persisted on multivariable logistic regression with OASIs being 2.39 (95% CI = 1.5-3.9) times more likely with physician delivery when controlling for maternal history of heart disease (aOR = 3.9, 95% CI = 1.03-14.6), episiotomy (aOR = 3.1, 95% CI = 2.0-4.9), increasing maternal age (aOR = 1.08, 95% CI = 1.04-1.1), decreasing maternal BMI (aOR = 0.95, 95% CI = 0.92-0.99), non-White race (aOR = 0.61, 95% CI = 0.4-0.96), and increasing birthweight (aOR = 1.03, 95% CI = 1.02-1.05). Area under the curve for this model was 0.78 indicating strong predictive ability. With propensity score matching, OASIs remained higher amongst physicians compared to midwives (6.6% vs 1.8%, $P < 0.0001$) with an aOR of 3.8 (95% CI = 2.0-7.1).

CONCLUSION: OASIs were more common in physician compared to midwife deliveries even when controlling for other associated factors. Our model may be used as a pre-delivery tool to guide providers on OASIs risk and possible reduction strategies.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Taniya V. Walker: Nothing to disclose; Andrew D. Sparks: Nothing to disclose; Charelle M. Carter-Brooks: Nothing to disclose.

27 Withdrawn

28 Validation of prioritization scoring tools for triage of elective gynecologic surgery during the COVID-19 pandemic

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OBJECTIVES: The COVID-19 pandemic disrupted access to elective surgery. In order to resume surgeries, we implemented the medically-necessary time sensitive scoring tool (MeNTS) (Prachand et al. 2020) and the modified Elective Surgery Acuity Scale (ESAS)to help stratify overall risk of operating on an individual basis. However, these surgical tools have not been validated for gynecologic surgery. Our objective was to evaluate the internal validity and inter-rater reliability of these scoring tools using a cohort of our faculty gynecologic surgeons.

MATERIALS AND METHODS: To assess internal validity and inter-rater reliability of the MeNTS and ESAS scoring tools, faculty were asked to complete a scoring survey with a series of five de-identified patient cases and one fictitious case written and scored by the chairperson of the Department of Obstetrics and Gynecology. Faculty scores for the fictitious case were compared to the "expert" score given by our chairperson. This served to assess internal validity or accuracy of our study. Inter-rater reliability was assessed through faculty scoring of 5 de-identified patient cases. The reliability coefficient was determined using Cohen's kappa.

RESULTS: To assess the accuracy of tools, we asked faculty to score a fictitious case written by the chairperson of our department, using the MeNTS and ESAS tier tools. Average scores were compared against the chairpersons' "expert score" (Figure 1, Table 1). The MeNTS inter-rater reliability showed good agreement across 5 cases and 8 faculty raters, kappa coefficient = 0.626. The ESAS tier analysis showed poor inter-

rater reliability across the 5 cases and 8 faculty raters, kappa coefficient = 0.157. Last, the surgeon consensus score showed fair inter-rater reliability, kappa coefficient = 0.237. Results shown in Table 2.

CONCLUSION: The MeNTS scoring tool appears to provide the most consensus across faculty gynecologic surgeons with most faculty agreeing on the associated risk with procedures in regard to patient and disease factors as well as medical resources.

Table 1. One Sample t-test for Faculty MeNTS and ESAS Tier Scores

	MeNTS Score	ESAS Tier
Mean Faculty Score	40.5	4.75 (Tier 2b-3a)
Expert Score	XX	XX
One Sample t-test	XX	XX

Table 2. Inter-Rater Reliability of Scoring Tools

Scoring Tool	Kappa Coefficient	Interpretation
MeNTS	0.626	Good
ESAS Tier	0.157	Poor
Surgeon Consensus	0.237	Fair

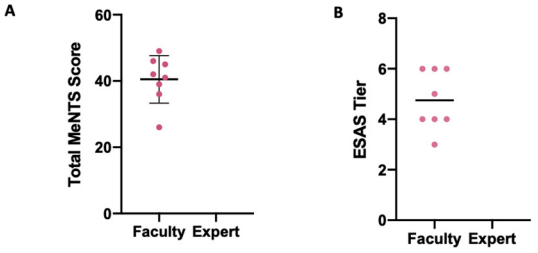

Figure 1. Distribution of Faculty Scores Compared to Expert Scores
Using a one-sample t test, the faculty cohort of MeNTS scores and ESAS tier scores for the fictitious case will be evaluated, n=8.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Sophie H. Guénin: Nothing to disclose; Amythis Soltani: Nothing to disclose; Cara L. Grimes: Provepharm, Hourly rate, Consultant; Johnson and Johnson, Hourly rate, Expert Witness; Camille A. Clare: Nothing to disclose; Gizelka David-West: Nothing to disclose; Julia G. Keltz: Nothing to disclose; Sharifa Menon: Nothing to disclose; Sean S. Tedjarati: Nothing to disclose; Tana Pradhan: Novartis, Nothing, Spouse is employee.

29 Moderate versus general anesthesia for operating room hysteroscopy: A cost analysis

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OBJECTIVES: Hysteroscopy is a procedure that is moving out of the operating room and into the office and ambulatory centers, as it has found to be safe and feasible in these settings. However, many gynecologists are still restricted to taking their patients to the operating room. At our institution there is a high volume of hysteroscopy performed by gynecologists in the operating room, and there is wide variation in the anesthesia care given. The primary objective is to perform a cost analysis for general anesthesia versus moderate sedation for hysteroscopic procedures in the operating room. Our secondary purpose is to compare additional patient outcomes including OR time, PACU time, and opioid requirements.

MATERIALS AND METHODS: Subjects were identified through a search of CPT codes using the Deep Six Cohort Builder from January 1, 2018, through December 31, 2018. Inclusion criteria included patients who had a hysteroscopy procedure at our institution, an urban tertiary care center, and were at least 18 years old. Patients were excluded who had a concurrent procedure which required general anesthesia or an emergent procedure. The remaining variables were extracted from the electronic medical record. Subjects who had a polypectomy and myomectomy were placed in two separate groups for analysis. These two groups were subsequently analyzed by anesthesia type: general anesthesia with endotracheal tube (ETT), general with laryngeal mask airway (LMA), and monitored anesthesia care (MAC). Data was analyzed using the Kruskal-Wallis test and Chi-Square test.

RESULTS: There were 467 patients included in the analysis (355 polypectomy and 112 myomectomy). For polypectomy there were 35 (ETT), 273 (LMA), and 45 (MAC) subjects. For myomectomy 14 (ETT), 90 (LMA), and 8 (MAC). General anesthesia with ETT had a higher cost compared to both general LMA and MAC for myomectomy and polypectomy ($P = 0.0225$, and $P = 0.005$). There was no difference in cost between general LMA and MAC ($P = 0.36$ and $P = 0.10$). General anesthesia ETT had longer OR times compared to LMA and MAC but no difference in PACU time or opioid use. For polypectomy, OR times for LMA use was also longer than MAC (60 minutes vs 54 minutes, $P = 0.008$). No patient factors could account for the use of an ETT or LMA; rather the chart review showed only anesthesiologist preference for the method.

CONCLUSION: Hysteroscopy is a safe, relatively short procedure, shown to be safe in the office or ambulatory setting. Efforts must be made to minimize cost and intervention in the main OR given the low reimbursement of these procedures. General anesthesia with ETT had higher costs and longer OR times. Most patients received LMA for airway support, which for polypectomy had longer OR times compared with MAC. Going forward, this data will help standardize anesthesia care for hysteroscopy and guide implementation for a hysteroscopy ERAS protocol that could be used across multiple settings.

DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS: Andrea L. Molina: Nothing to disclose; Kelly Wright: Caldera Medical, Honorarium, Consultant; Cooper Surgical, Honorarium, Consultant; Hologic, Honorarium, Consultant; Karl Storz, Honorarium, Consultant; UVision360, Honorarium, Consultant; Naomi Greene: Nothing to disclose.

30 Hemostatic agent use in outpatient benign hysterectomy: A nationwide assessment

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OBJECTIVES: To identify nationwide trends in hemostatic agent (HA) use during outpatient benign hysterectomy between October 2015 and December 2019.

MATERIALS AND METHODS: Using Current Procedural Terminology codes captured in the Vizient Clinical Data Base, a national encounter-based dataset, female patients of at least 18 years who underwent an outpatient benign hysterectomy between October 2015 and December 2019 were identified. An HA is a topically