

Henry Ford Health

## Henry Ford Health Scholarly Commons

---

Women's Health Meeting Abstracts

Obstetrics, Gynecology and Women's Health  
Services

---

3-1-2022

### Racial and ethnic disparities in pelvic floor disorder awareness

N. Megahed

S. Pai

E. Robison

Rebeccah Briskin

K. Menhaji

*See next page for additional authors*

---

Follow this and additional works at: [https://scholarlycommons.henryford.com/  
womenshealth\\_mtgabstracts](https://scholarlycommons.henryford.com/womenshealth_mtgabstracts)

---

---

## Authors

N. Megahed, S. Pai, E. Robison, Rebeccah Briskin, K. Menhaji, S. Spector, R. Hidalgo, and D. Antosh

Research Support; Elsevier, Book Editor, Royalties, Sierra M. Jansen: Nothing to disclose, Flora Abudushalamu: Nothing to disclose, Jamie L. Griego: Nothing to disclose, Gena Dunivan: Pelvalon, Researcher, Research Support; Viveve, Researcher, Research Support; Renovia, Researcher, Research Support; ABOG/ACOG, Examiner, committee member, Travel reimbursement, Yuko Komesu: Nothing to disclose, Janet M. Page-Reeves: Nothing to disclose.

### 32 Non-white women are less likely to have apical suspension at the time of hysterectomy after controlling for geographic variations in a nationally representative cross-sectional study using HCUP



R. Wang, E. Tunitsky

Hartford Hospital, Hartford, CT

**OBJECTIVES:** To evaluate the differences in concurrent apical prolapse repair at the time of hysterectomy among racial groups 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 HCUP National Inpatient Sample, a national database of inpatient encounters that includes all payers and a representative sample within the United States. Race and ethnicity are patient reported. Hysterectomies and apical prolapse repair procedures are identified using procedural codes. Differences in concurrent apical prolapse repair with hysterectomy are analyzed by racial groups and adjusted for potential confounders.

**RESULTS:** In 2017, 35,865 women 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. A total of 2,395 (6.9%) of women underwent concurrent apical prolapse repair at the time of hysterectomy, with Black and Native American women having the lowest rates (3.6% and 3.8% respectively) ( $P<0.001$ ) (Figure 1). Among women with vaginal hysterectomies, 827 (35%) had concurrent apical repair, with the lowest rate among Native American and Black women (12% and 37% respectively) ( $P<0.001$ ) (Figure 1). In multivariate regressions, Black (OR 0.60, 0.42-0.86,  $P=0.006$ ), Hispanic (OR 0.73, 0.57-0.94,  $P=0.015$ ), and Asian race (OR 0.48, 0.29-0.81,  $P=0.006$ ) were significant predictors of lower rate of concurrent apical repair with vaginal hysterectomy after adjusting for patient, hospital, community, payer, and geographic factors (Table 1). Similar results were obtained for concurrent apical repair with any hysterectomy (Table 1).

**CONCLUSION:** A small minority of patients undergo concurrent apical prolapse repair with hysterectomy. In this nationally representative sample controlling for not only patient characteristics, but also potential biases in practice patterns across geographic areas, payers, and hospital factors, Black, Hispanic, and Asian races remained significant predictors of lower rate of concurrent apical suspension.

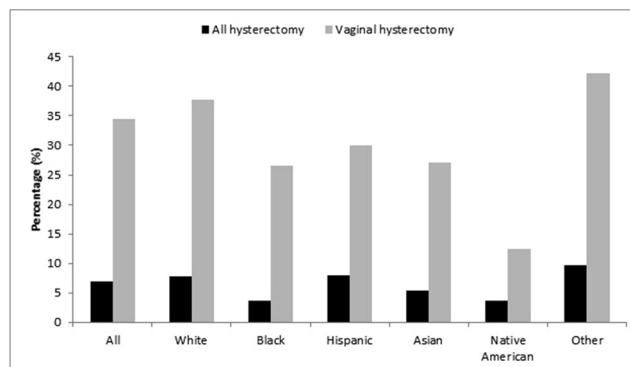


Figure 1. Rates of concurrent apical suspension at the time of any hysterectomy and vaginal hysterectomy by patient reported race

Table 1. Multivariate logistic regression of concurrent apical suspension at the time of hysterectomy\*

	Adjusted Odds Ratio	95% Confidence Interval	P value	Adjusted Odds Ratio	95% Confidence Interval	P value	
Any hysterectomy (N=34,123), Concurrent apical prolapse repair				Vaginal hysterectomy (N=2,353), Concurrent apical prolapse repair			
White	1 (reference)			1 (reference)			
Black	0.58	0.51-0.67	<0.001	0.60	0.42-0.86	0.006	
Hispanic	1.14	1.00-1.30	0.042	0.73	0.57-0.94	0.015	
Asian	0.64	0.50-0.82	<0.001	0.48	0.29-0.81	0.006	
Native American	0.66	0.29-1.51	0.328	0.33	0.04-2.83	0.310	
Other race	1.31	1.07-1.60	0.007	1.23	0.81-1.88	0.331	

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

### DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:

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

### 33 Racial and ethnic disparities in pelvic floor disorder awareness



N. Megahed<sup>1</sup>, S. Pai<sup>1</sup>, E. Robison<sup>2</sup>, R. Briskin<sup>3</sup>, K. Menhaji<sup>4</sup>, S. Spector<sup>5</sup>, R. Hidalgo<sup>6</sup>, D. Antosh<sup>1</sup>

<sup>1</sup>Houston Methodist Hospital, Houston, TX, <sup>2</sup>The Ohio State, Columbus, OH, <sup>3</sup>Henry Ford Hospital, Detroit, MI, <sup>4</sup>Icahn School of Medicine at Mount Sinai, New York, NY, <sup>5</sup>Cooper University Hospital, Camden, NJ, <sup>6</sup>University of South Florida, Tampa, FL

**OBJECTIVES:** Pelvic floor disorders (PFD) affect the quality of life for many women and can be a significant cause of distress. With the United States' aging population, PFD are becoming increasingly prevalent. Previous population based studies identified both differences in prevalence and baseline knowledge of PFD by race and ethnicity. These prior studies assessing PFD knowledge were limited to single geographical areas or institutions. We aim to conduct a multicenter study across the United States to better understand the baseline knowledge and perceptions of PFD and its variance across different races and ethnicities. Our goal is to provide data that will help deliver culturally competent information to patients.

**MATERIALS AND METHODS:** This was a multicenter cross-sectional study involving six sites. Upon initial presentation to a urogynecology clinic, patients were evaluated with the Prolapse and Incontinence Knowledge Questionnaire along with additional questions aimed to assess differences in PFD descriptive language, barriers to care, and attitude towards PFD. Surveys were distributed at participating institutions from October 2019 to February 2021. Statistical analyses were performed with Fisher's exact test and Chi-square test, using  $p < 0.05$  for statistical significance.

**RESULTS:** A total of 287 women completed the survey, with 27 excluded due to omission of race and/or ethnicity responses. Respondents identified their ethnicity as Hispanic (21.8%) and race as White (70.5%), African American (AA) (19.2%), and Other Women of Color (OWOC) (10.3%). Overall, the mean percent correct for the urinary incontinence (UI) and pelvic organ prolapse (POP) subscores were  $61.2 \pm 28.2$  and  $60.5 \pm 28.2$ , respectively. AA and OWOC had lower scores compared to White respondents in both UI (AA  $60.7 \pm 30.1$ ; OWOC  $46.8 \pm 31.2$ ; W  $63.5 \pm 26.5$ ;  $p = 0.018$ ) and POP (AA  $55.5 \pm 30.1$ ; OWOC  $48.9 \pm 31.0$ ; W  $64 \pm 26.2$ ;  $p = 0.011$ ). Hispanic women scored lower in both UI ( $43.9 \pm 29.8$  vs  $66.5 \pm 25.3$ ,  $p < 0.001$ ) and POP ( $46.2 \pm 28.4$  vs  $66.5 \pm 25.3$ ,  $p < 0.001$ ) when compared to non-Hispanic respondents. AA and OWOC had decreased knowledge of POP language compared to White respondents ( $32.3 \pm 30.8$  % correct vs  $35.4 \pm 33.6$  % correct vs  $50.4 \pm 32.9$  % correct,  $p < 0.001$ ). This was similar for Hispanic compared to non-Hispanic respondents ( $33.3 \pm 31.2$  % correct vs

$40.1 \pm 32.5\%$  correct,  $p < 0.001$ ). Responses to UI and POP misconception questions were not different by race or ethnicity.

**CONCLUSION:** This is the first multicenter, cross-sectional survey of a diverse patient population assessing knowledge and perception of PFD. We observed differences between baseline knowledge and language proficiency of PFD amongst AA, White, and OWOC, as well as between Hispanic and non-Hispanic women. This suggests the presence of racial disparities in women pursuing urogynecologic care and highlights the importance of delivering culturally sensitive information to educate women of diverse backgrounds.

#### DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:

Nadia Megahed: Nothing to disclose; Shweta Pai: Nothing to disclose; Elizabeth Robison: Nothing to disclose; Rebeccah Briskin: Nothing to disclose; Kimia Menhaji: Nothing to disclose; Sean Spector: Nothing to disclose; Ryan Hidalgo: Nothing to disclose; Danielle Antosh: Nothing to disclose.

### 34 Opioid use following laparoscopic surgery for endometriosis and chronic pelvic pain



C. Heres<sup>2</sup>, N. Rindos<sup>3</sup>, I. Fulcher<sup>4,5</sup>, S. Allen<sup>1</sup>, N. King<sup>1</sup>, S. Miles<sup>6</sup>, N. M. Donnellan<sup>1</sup>

<sup>1</sup>Obstetrics, Gynecology and Reproductive Sciences, University of Pittsburgh, Magee-Womens Hospital, Pittsburgh, PA, <sup>2</sup>University of Pittsburgh School of Medicine, Pittsburgh, PA, <sup>3</sup>Obstetrics and Gynecology, Allegheny General Hospital, Pittsburgh, PA, <sup>4</sup>Harvard Data Science Initiative, Cambridge, MA, <sup>5</sup>Department of Global Health and Social Medicine, Harvard Medical School, Boston, MA, <sup>6</sup>Mike O'Callaghan Hospital, Nellis AFB, NV

**OBJECTIVES:** To measure postoperative opioid use following laparoscopic surgery for endometriosis and chronic pelvic pain (CPP) and identify patient characteristics associated with greater postoperative opioid medication requirements.

**MATERIALS AND METHODS:** This was a prospective, survey-based study of 100 women undergoing laparoscopic surgery for endometriosis or CPP by fellowship-trained, minimally invasive gynecologic surgeons at a tertiary care academic center. Following consent, patients completed a preoperative survey inquiring about current pain, anticipated postoperative pain, and recent pain medication use. Subjects completed seven surveys within 30 days postoperatively regarding the quantity and type of pain medication used and current pain levels. Baseline demographics, medical history, and perioperative care details were abstracted from the medical records. Descriptive statistics were calculated for opioid pill usage. Bivariate analyses were performed to compare opioid use at postoperative day 28 across patient and surgical characteristics via Wilcoxon rank sum tests.

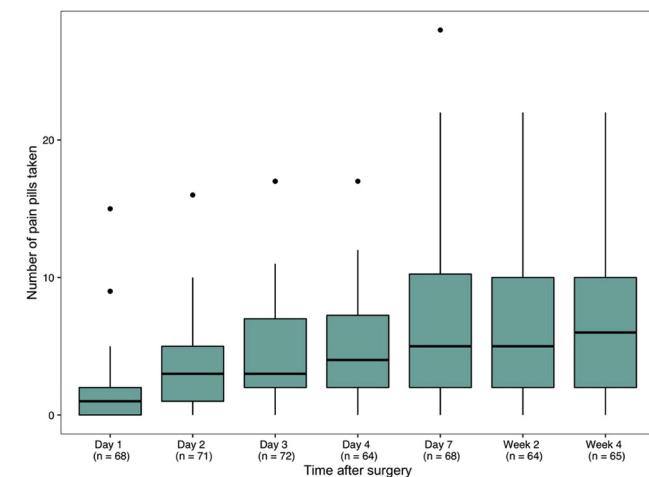
**RESULTS:** 100 patients were recruited, and 8 patients were excluded for receiving additional narcotics from outside sources, for a final sample size of 92 patients. All patients responded to the pre-operative survey with postoperative survey response rates ranging from 72% (days 4, 14, and 28) to 80% (day 3). The average number of pain pills prescribed to patients was 10.5, with a minimum of 4 pills ( $n=1$ ) and maximum of 20 ( $n=4$ ). Patients reported a cumulative 277.5 opioid pills remaining at the day 28 survey, with a mean of 4.3. 34% ( $n=22$ ) of patients had no pills left, and 35% ( $n=23$ ) had at least 7 pills remaining. The mean number of pills taken by day 1 was 1.8, by day 2 was 3.1, by day 3 was 4.5, by day 4 was 4.7, by day 7 was 6.7, and by day 28 was 6.8 (Figure 1).

There was a trend of greater opioid use in patients with preoperative diagnoses of CPP and mood disorders (7.93 vs. 5.96;  $p=0.079$ ; 7.79 vs. 5.25;  $p=0.19$ ). Undergoing a hysterectomy was

associated with a significant increase in postoperative narcotic use (9.66 vs. 5.59;  $p=0.018$ ). There were no statistical differences in number of pills taken by preoperative pain score categories, longer operative time, presence of deep endometriosis, or pathology confirmed endometriosis (all  $p > 0.37$ ).

**CONCLUSION:** Most patients undergoing laparoscopic surgery for endometriosis and CPP had a lower postoperative opioid requirement than prescribed. Average opioid use in our cohort is similar to trends reported for minimally invasive surgery for non-chronic pain indications, suggesting surgeons do not need to prescribe more postoperative narcotics for a majority of pelvic pain patients. Patients with long-standing CPP syndrome or mood disorders may represent a population requiring additional postoperative opioid requirements. Larger multi-center trials are needed to better characterize trends in this population.

Figure 1. Cumulative number of pills taken by postoperative day



#### DISCLOSURE OF RELEVANT FINANCIAL RELATIONSHIPS:

Caroline Heres: Nothing to disclose; Noah Rindos: Nothing to disclose; Isabel Fulcher: Nothing to disclose; Sarah Allen: Nothing to disclose; Nathan King: Nothing to disclose; Shana Miles: Nothing to disclose; Nicole M. Donnellan: Nothing to disclose.

### 35 Factors associated with publication of clinical trials evaluating hysterectomy



A. Tjitra<sup>1</sup>, J. Foote<sup>2</sup>, N. Mahnert<sup>1</sup>

<sup>1</sup>OB/GYN, University of Arizona College of Medicine - Phoenix, Phoenix, AZ, <sup>2</sup>Epidemiology and Biostatistics, Mel and Enid Zuckerman College of Public Health, University of Arizona, Phoenix, AZ

**OBJECTIVES:** Early discontinuation and non-publication are common issues in clinical research. To promote transparency and accountability, [ClinicalTrials.gov](#) was released in the early 2000s as an open access registry, mandating public availability of trial outcomes. Among studies registered in [ClinicalTrials.gov](#) under 'hysterectomy', we sought to ascertain time to study completion and publication, and to determine what factors are associated with a higher likelihood of publication.

**MATERIALS AND METHODS:** A query to the [ClinicalTrials.gov](#) database with the search term 'hysterectomy' was performed from 1/1/2003 through 3/5/2020. Publicly available information included investigators, study title, type of research, start and completion dates, funding entity, and country of study. All studies were searched on