health plan database. Inverse propensity weighing was used separately for benign and malignant groups to balance baseline characteristics. Primary outcomes of 30-day SSI, AL and major morbidity were assessed using multivariate logistic regressions that adjusted for race, census region, household income, diabetes and other unbalanced variables following propensity weighting.

Results: A total of 224,687 hysterectomies (benign 186,299; malignant 38,388) were identified. Median age was 45 years for the benign and 54 years for the malignant cohort. Type of surgery was as follows: benign - laparoscopic/robotic 27.2%, laparotomy 32.7%, vaginal 40.2%; malignant - laparoscopic/robotic 28.8%, laparotomy 47.6%, vaginal 23.6%. Bowel resection was performed in 0.4% of the benign and 2.8% of the malignant cohort. Type of bowel preparation was as follows: benign - none 93.8%, MBP only 4.6%, OA only 1.1%, MBP+OA 0.5%; malignant: none 87.2%, MBP only 9.6%, OA only 1.8%, MBP+OA 1.4%. Use of BP did not result in decreased SSI, ALs or major morbidity following benign or malignant hysterectomy (**Table 1A.**). Among malignant abdominal hysterectomies, there was no difference in the rates of infectious morbidity between MBP alone, OA alone, or MBP with OA compared to no BP (**Table 1B.**).

Conclusions: BP does not protect against SSI or major morbidity following benign or malignant hysterectomy, regardless of surgical approach, and may be safely omitted.

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Poster #49

The gender authorship gap in Gynecologic Oncology research

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Objectives: Women now outnumber men in obstetrics and gynecology, which has the highest proportion of female faculty members (58%) among all specialties. From 1970-2004, female first authorship and senior authorship in *Obstetrics and Gynecology* increased from 6.7% to 40.7% and 6.8% to 28.0%, respectively. However, gender-specific publishing data are lacking within gynecologic oncology, which has smaller proportions of female faculty members. We examined contribution by gender to the subspecialty's flagship journal over time to identify gaps in gender representation.

Methods: We identified original articles from *Gynecologic Oncology* for the years 1972-73, 1980, 1990, 2000, and 2014. We determined sex for the first and last authors of each article. We used chi-square tests to compare gender distributions within and between the first and last years studied (1972-73 and 2014) as well as linear regression to model trends over time. All analyses were performed using R.

Results: We reviewed 1201 publications. In 1972-73, women comprised 11% of first authors (3/27, $\chi^2=16.3$, $p<0.01$) and 0% of senior authors (0/20). In 2014, 58% (232/398, $\chi^2=10.9$, $p<0.01$) of first authors and 37% (144/389, $\chi^2=26.2$, $p<0.01$) of senior authors were female. Female first and senior authorship increased significantly from 1972 to 2014 (first: $\chi^2=20.9$, $p<0.01$; senior: $\chi^2=9.9$, $p<0.01$). The number of female first authors increased markedly after 2000, while male first authors declined (Fig 1). Female senior authors were more likely to have female first authors than male senior authors (54.2% vs. 28.7% across all years); furthermore, the proportion of female senior authors with female first authors (as opposed to males) has increased over time ($T=10.5$, $p<0.01$).

Conclusions: The publication gender gap in gynecologic oncology's journal has reversed among first authors and narrowed among senior authors. A substantial divide remains between men and women at the senior author level. Other fields have reported a similar pattern of increases in both first and senior authorship over time, with the latter lagging behind the former. We observed that papers with female senior authors were more likely to have female first authors, possibly illustrating the effects of mentoring by women in senior roles. Subspecialty-wide gender equity initiatives should encourage continued mentorship of women by female colleagues.

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