for 91 incisions, occurring in 38 of 68 incisions (56%) closed with barbed, polydioxanone suture, and 53 of 105 incisions (50%) closed with braided polyglactin 910 suture (p=0.487). Univariate analysis revealed no significant difference in dehiscence rates between closure techniques, when stratified by cancer diagnosis, radicality, or attending surgeon. Univariate analysis also revealed no significant difference in dehiscence rates between smokers and non-smokers, at 56% vs 46% respectively. There was no significant difference in postoperative pain or in rates of suture removal at follow up. Multivariate analysis, controlling for body mass index, operating time, estimated blood loss, age, smoking, cardiovascular disease, history of vaginal delivery, preoperative antibiotics and immunosuppression, demonstrated no statistical significance in dehiscence (p=0.55). In the multivariate analysis, only body mass index significantly affected dehiscence rates (p=0.0053).

Conclusions: The use of barbed, polydioxanone suture is a viable technique for the closure of both radical and nonradical vulvar excisions. Barbed, polydioxanone suture did not result in significantly increased rates of incision dehiscence in vulvar surgery. This initial study provides a basis for future randomized controlled studies to evaluate barbed, polydioxanone suture in vulvar incision closures.

Poster #7
Prevalence of pelvic floor dysfunction among cervical cancer survivors

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Objectives: The prevalence and severity of pelvic floor dysfunction among cervical cancer survivors is unknown, but has been hypothesized to be higher than the general population. This may have a significant impact on quality of life in these women. This goal of this study is to evaluate the prevalence of pelvic floor dysfunction in cervical cancer survivors and ascertain the most common pelvic floor complaints in these patients.

Methods: An IRB-approved prospective survey was conducted among cervical cancer survivors who had completed their most recent treatment ≥ 3 months prior. Patients with active disease, those currently undergoing therapy of any kind, or those with history of pelvic exenteration were excluded. Participants completed a survey developed from the NCI's Patient-Reported Outcomes version of the Common Terminology Criteria for Adverse Events (PRO-CTCAE) during their routine surveillance visit. Summary statistics were used to describe demographic and clinical factors. Fischer's exact test, two sample t-test, Wilcoxon rank sum test, and chi-square test were used where appropriate.

Results: In total, 23 patients met inclusion criteria. Of these, 65.2% were Caucasian, 65.2% were stage 1, and the median BMI was 30. For primary therapy, 73.9% received radiation with or without chemotherapy, 17.4% received chemotherapy alone, and 56.5% received surgery with or without adjuvant therapy. The majority of patients (86.9%) reported some element of pelvic floor dysfunction. Regarding GI symptoms, 47.8% reported constipation, 39.1% reported diarrhea, and 17.3% reported fecal incontinence. In regards to urinary symptoms, 82.6% reported urinary frequency, 60.8% reported urinary incontinence, and 60.8% reported urinary urgency. The prevalence of pelvic pain was 39%. Of the 13 patients who answered questions about sexual dysfunction, 27% reported dyspareunia.

Conclusions: Pelvic floor dysfunction is very common among cervical cancer survivors. The most frequently reported symptoms are urinary, with more than three-fourths of patients noting urinary frequency. Patient accrual for this study is ongoing to obtain a larger sample size. The knowledge gained from this data will help to determine how interventions, such as pelvic floor physical therapy, could improve quality of life in this patient population.

Poster #8
Postoperative incisional cryoanalgesia for robotic hysterectomy

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Objectives: Cryoanalgesia has the ability to reduce local inflammation by producing isolated vasoconstriction and decreasing nerve conduction velocity. This process could theoretically decrease nociception at incision sites for postoperative patients and reduce need for opioid pain medications. The objective of this study was to obtain and compare Visual Analog Pain Scores (VAS) for robotic hysterectomy patients in the first postoperative 24 hours with and without application of cryoanalgesia to abdominal incision sites.

Methods: Consecutive patients receiving postoperative care for robotic hysterectomy following intervention for application of ice packs to abdominal incisions in the first postoperative 24 hours from November 2016 to May 2017 were compared to consecutive historical controls in a similar time period (April 2016 to October 2016). Patient demographics, medical comorbidities, surgical procedure, history of chronic pain medicine use, Visual Analog Pain Scores (VAS), total narcotic use and compliance to cyroanalgesia were collected. Student's t test, Analysis of Variance, the Tukey-Kramer method and multiple regression analysis were used for statistical analysis.

Results: A total of 93 patients were evaluated following ice pack intervention, and 72 patients were evaluated prior to intervention. Prior to the intervention, no patients received ice packs for cyroanalgesia. Following the intervention, all patients received an order for ice packs, with only 30 patients receiving ice, a 32% rate of compliance. Visual Analog Pain Scores were recorded over the first 24 postoperative hours in three separate 8-hour time frames using the Tukey-Kramer method for adjustment for multiple comparisons. In the pre-intervention group, the average VAS for each time frame 0-8 hours, 9-16 hours and 17-24 hours was 4.1, 3.1 and 3.9 respectively. For the post-intervention group, the average VAS for each time frame was 3.9, 3.1 and 3.9 respectively. There was no difference in VAS between the pre- and post-intervention groups (p=0.98). Similarly, there was no significant difference between patients that did not receive ice packs to those who did (p=0.62). A statistically significant difference in VAS was noted in both the pre- and post- intervention groups from 0-8 hours and 9-16 hours (p=0.04 and p=0.01, respectively). Multiple Regression Analysis concluded that VAS was positively correlated with number of narcotic pills used (p < 0.0001), but no correlation with age, BMI, estimated blood loss or ASA physical status classification.

Conclusions: Incisional cryoanalgesia did not improve Visual Analog Pain Scores during the first postoperative 24 hours in patients undergoing robotic hysterectomy. Overall low pain scores are reported following robotic hysterectomy where minimal analgesia is required.

Poster #9
Expression and function of ER-B in premenopausal endometrial cancers

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