flap or gracilis muscle) have been used for recurrent RVF. We aimed to review our experience with gracilis muscle interposition (GMI) for RVF due to obstetric injury.

**METHODS:** A retrospective analysis of patients who underwent GMI for RVF after obstetric injury from February 1995 to December 2019 was undertaken. Patient demographics, number and prior treatments, comorbidities, tobacco use, postoperative complications, additional procedures, and outcome were assessed. Success was defined as absence of leakage from the repair site after stoma reversal.

**RESULTS:** Six of 119 patients who underwent GMI did so for recurrent RVF attributable to obstetric injury. Median age was 34.2 (28-48) years. All patients had at least one previously failed procedure [median: 3 (1-7)] including endorectal advancement flap, fistulotomy, vaginoplasty, mesh interposition, and sphincteroplasty. All patients underwent fecal diversion prior to or at initial procedure. Success was achieved in 4/6 (66.7%) patients; 2 underwent further procedures (one fistulotomy and one rectal flap advancement) for a final 100% success rate as all ileostomies were reversed. Morbidity was reported in 3 (50%) patients, including wound dehiscence, delayed rectoperineal fistula, and granuloma formation in one each, all managed without surgery. There was no morbidity related to stoma closure.

**CONCLUSION:** GMI is a valuable tool for recurrent RVF after obstetrical trauma. Our ultimate success rate was 100% with a relatively low morbidity rate.

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**Impact of Enhanced Recovery Program on Clinical Outcomes after Elective Colorectal Surgery in a Rural Hospital**

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**INTRODUCTION:** The main purpose was to determine the impact on postoperative outcome of a standardized enhanced recovery program (ERP) for elective colorectal surgery in a rural hospital.

**METHODS:** A prospective series of patients (N=80) undergoing elective colorectal resection completing a standardized ERP protocol in 2018-2020 (ERP group) was compared to patients (N=80) operated at the same rural hospital in 2013-2015 (pre-ERP group). The exclusion criteria were: ASA IV, TNM stage IV, inflammatory bowel disease, emergency surgery, and rectal cancer. The primary outcome was hospital length of stay (LoS) which was used as an estimate of functional recovery. Secondary outcomes included: postoperative complications, 30-day readmission, mortality, and factors predicting prolonged hospital stay.

**RESULTS:** Age, gender and body mass index were comparable in both groups. Laparoscopic approach was performed in 95% of patients in the ERP group vs 0% in pre-ERP group. The median adherence to ERP protocol elements was 68%. The median hospital LoS in ERP-group was 5 days (IQR, 4-7 days) vs 10 days (IQR, 9-14 days) in the pre-ERP group (p<0.0001). A 31% reduction of postoperative complications was observed in the ERP group with no significant difference in 30-day mortality and re-admission rates. After adjusting for potential confounders, following a conventional peri-operative protocol was the only independent factor predicting a prolonged hospital LoS (p<0.0001).

**CONCLUSION:** Although limited hospital resources are perceived as a barrier to ERP implementation, the current experience demonstrates how adopting an ERP program in a rural area is feasible and effective, despite it requires greater effort.

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**Hospital Cost Associated with Preventing and Managing Iatrogenic Ureteral Injury in Inpatient Elective Colectomy**

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**INTRODUCTION:** There have been debates about whether preoperative ureteral catheterization/stenting (PUC) could identify and prevent IUI in abdominopelvic surgeries. There is also limited information on whether PUC can save hospital costs.

**METHODS:** Inpatient elective colectomies (Oct 2015-Dec 2019) were retrospectively identified in the Premier database and followed for up to 120 days. Surgeries with PUC were propensity-score (PS) matched to surgeries without PUC to compare IUI incidence and to estimate additional PUC costs for hospital. IUI costs for hospital were estimated as the median difference between PS-matched IUI and no-IUI pairs. The economic impact to hospitals for PUC was estimated by adding PUC and IUI costs, considering the difference in IUI rates with and without PUC.

**RESULTS:** PUC was used in 6.75% (95% CI: 6.62-6.88) of 144,865 inpatient elective colectomies. The overall IUI rate was 1.50% (95% CI: 1.44-1.57) and around 60.0% were identified intraoperatively. After matching, the incidence of IUI was 1.44% lower with PUC than without PUC; the number needed to treat was 69 surgeries to prevent one IUI with PUC. The additional cost for PUC was $2,053 ($1,805-$2,289). Total postoperative IUI cost was almost three-times more than intraoperative IUI cost for the hospital. Considering IUI cost offsets, the economic impact to hospitals was $2,026 per surgery with PUC.

**CONCLUSION:** In this dataset, although PUC decreased overall IUI risk during inpatient elective colectomy, PUC use did not lower hospital costs.