# UK Clinical Guideline for best practice in the use of vaginal pessaries for pelvic organ prolapse

**March 2021**

Developed by members of the UK Clinical Guideline Group for the use of pessaries in vaginal prolapse representing: the United Kingdom Continence Society (UKCS); the Pelvic Obstetric and Gynaecological Physiotherapy (POGP); the British Society of Urogynaecology (BSUG); the Association for Continence Advice (ACA); the Scottish Pelvic Floor Network (SPFN); The Pelvic Floor Society (TPFS); the Royal College of Obstetricians and Gynaecologists (RCOG); the Royal College of Nursing (RCN); and pessary users.

Funded by grants awarded by UKCS and the Chartered Society of Physiotherapy (CSP).

This guideline was completed in December 2020, and following stakeholder review, has been given official endorsement and approval by:

- British Association of Urological Nurses (BAUN)
- International Urogynecological Association (IUGA)
- Pelvic Obstetric and Gynaecological Physiotherapy (POGP)
- Scottish Pelvic Floor Network (SPFN)
- The Association of Continence Advice (ACA)
- The British Society of Urogynaecology (BSUG)
- The Chartered Society of Physiotherapy (CSP)
- The Pelvic Floor Society (TPFS)
- The Royal College of Nursing (RCN)
- The Royal College of Obstetricians and Gynaecologists (RCOG)
- The United Kingdom Continence Society (UKCS)

**Review**

This guideline will be due for full review in 2024.

All comments received on the POGP and UKCS websites or submitted here: pessarycg@gmail.com will be included in the review process.

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## Acknowledgement

Thanks to Allison Gorman at Mediplus Ltd for providing the pessaries shown in the images in Appendix 5.

Thanks to Rebecca Barrett for providing the infographics in Appendix 6.

# UK Clinical Guideline for best practice in the use of vaginal pessaries for pelvic organ prolapse

The shared priorities of women and healthcare professionals for future research in pessary use for prolapse, published in 2018 demonstrated that many uncertainties reported by pessary users relate to routine pessary practice.[1] The absence of a standardised, evidence-based UK guideline has been highlighted. The UK Clinical Guideline Group for best practice in the use of vaginal pessaries for pelvic organ prolapse was formed in 2019 in response to this (Appendix 1).

## Aims

This consensus document aims to deliver a best practice guideline for healthcare professionals providing non-surgical treatment for pelvic organ prolapse using vaginal pessaries, and information for women seeking this treatment.

The guideline aims to standardise pessary management by providing clinical guidance in pessary use that is based on the evidence, where available (Appendix 2), or expert clinical consensus within the guideline group. Specific recommendations with strength of evidence gradings are not made. The scope of this guideline is intended to address areas of pessary care provision that may create barriers and variation in clinical practice identified by the guideline group (Appendix 3). The addition of a training and competencies document is a key part of meeting this aim (Appendix 4).

It is expected that the involvement of the stakeholder groups will ensure wide dissemination of the document, and subsequent uptake of the recommendations for clinical provision of pessaries. The guideline is suitable for all healthcare professionals, but it is recognised that it may be used in different ways due to different levels of experience and training.

The multidisciplinary UK Guideline group aimed to:

- develop and widely publicise information for pessary users to inform, empower and manage expectations;

- develop a training competency framework for healthcare professionals with recommended levels for supervision, observation and assessment of competence;
- provide recommendations for data recording and audit, and as a consequence, facilitate future research; and
- maintain an established group to review future and emerging evidence.

The guideline is not intended as a substitute for advice and training from an appropriate healthcare professional and is expected to be part of a patient – centred treatment programme for pelvic organ prolapse.

## Diversity and inclusion

This document has been assessed by stakeholders as listed in Appendix 1, and after considering suggested amendments, there is no impact on any protected characteristics as far as we are aware. The guideline does not affect the diversity and inclusion policies in place in the individual organisations that implement the guidance within a pessary provision service.

# Best practice guideline

**Terminology**

The term “pelvic organ prolapse” will be used throughout this document, and shortened to “prolapse” for clarity if required. The term “vaginal prolapse” was considered more helpful by the pessary users and is used in the patient information sections.

The term “vaginal pessary” will be used throughout the document and shortened to “pessary” for clarity if required.

## Introduction

**Pelvic organ prolapse** is defined as the symptomatic descent of one or more of: the anterior vaginal wall, the posterior vaginal wall, the cervix or uterus, or the apex of the vagina (vault or cuff scar after hysterectomy).[2,3] The vagina can be considered as having anterior, posterior and apical compartments.

Common symptoms are:

- vaginal heaviness and bulge;
- bladder and bowel difficulties that may include urgency, frequency, leakage and incomplete emptying; and
- discomfort that may be felt vaginally, abdominally or during sexual activity and may include low back pain.

Many women may experience bladder, bowel and sexual symptoms that could be associated with but not caused by the prolapse. Some 20–40% of all women will experience prolapse symptoms that may be bothersome and affect their quality of life.[4,5,6]

Pelvic organ prolapse is measured by clinical examination, and staged according to the extent of downwards displacement (descent) of the most-affected vaginal compartment.

**Treatment** for pelvic organ prolapse should start with non-surgical (conservative) management options that may include: pelvic floor muscle training; lifestyle advice; a vaginal pessary to support

the prolapse; and if indicated, vaginal (topical) oestrogen for post-menopausal women. Non-surgical management options may be used in combination to maximise a reduction in symptoms. Surgical treatment may also be offered with the aim of restoring the vaginal anatomy. If the prolapse symptoms are not very bothersome, a woman may choose neither management option, and instead, wait to see if her symptoms worsen or improve. The treatment goals should be discussed to determine the management plan.

**Vaginal pessaries** are used intravaginally to try to restore the prolapsed organs to their normal position and relieve symptoms. Pessaries have been used for the management of pelvic organ prolapse for centuries and are widely used by healthcare professionals as a first-line treatment for prolapse. They are usually made of plastic or silicone and are available in a range of types and sizes. The ring pessary is the most commonly used. The basic design may have modifications such as folding notches to make insertion and removal easier, the addition of a knob to help with symptoms of stress urinary incontinence (SUI), or an interior surface to improve support centrally. Non ring-shaped pessaries such as the Gellhorn, shelf, or cube, may offer support for different stages and compartments of prolapse. Choice and fit of pessary are based on clinician experience, availability, whether the woman wants to be sexually active, and which type of pessary is retained and comfortable. The fitting process is “trial and error”, and several different sizes and types may need to be tried before the woman is comfortable during all activities and able to pass urine with the pessary in place.

## Pessary use for symptomatic pelvic organ prolapse best practice guidance

The clinical practice pathway for pessary provision and management (p13) follows the stages outlined below.

### Indications

A pessary may be offered to a woman:

- for short- or long-term management of bothersome symptoms of pelvic organ prolapse if she has a preference for or is willing to agree to a trial of pessary use, there are no contraindications (see below), and she understands that regular attendance for follow-up is required unless self-management is chosen and available;
- who has not completed her family and needs an interim solution for symptomatic prolapse until surgery, if indicated, can be considered at a later date; or
- to assess the effect of reducing a prolapse on bladder and bowel function prior to considering surgical management.

### Contraindications

A pessary should not be considered in the following situations:

- The woman is neither able to comply with regular follow-up, nor self-manage the pessary.
- There is active vaginal or pelvic infection, inflammation, unexplained bleeding, or ongoing vaginal or cervical cancer.
- The woman has had previous radiotherapy affecting the vaginal tissues.
- The vaginal tissue is severely atrophic and has not responded to pre-pessary oestrogen treatment.
- The vaginal space is too narrow or too short to fit a pessary.
- There is identifiable synthetic vaginal mesh erosion.

### Caution required

A pessary may be an option, but additional caution is required in the following situations:

- poor vaginal health requiring vaginal oestrogen therapy prior to a pessary fitting;
- a synthetic mesh has been placed in the vagina during previous surgery; and/or
- pre-existing vaginal pain (e.g. pudendal neuralgia).

## Information required for a woman considering a pessary

The following information should be given as part of the informed consent process:

- Fitting is by trial and error, and several pessary types and sizes may need to be tried before a comfortable, effective one is found.
- The fitting process may be uncomfortable.
- Regular follow-up and adherence to pessary care instructions are essential.
- Complications are minimised with good pessary follow-up, but may still occur. Even if these occur, the pessary may not need to be removed if the symptoms of the complication are minor, and the pessary remains comfortable and effective.
- Clear information about what to do in case of problems between follow-up appointments is required.

## Complications

The following table is based on the RCOG Clinical Governance Advice and describes how to present the risk of complications.[7]

| **Term** | **Equivalent numerical ratio** | **Colloquial equivalent** |
|---|---|---|
| *Very common* | 1/1 to 1/10 | A person in a family |
| *Common* | 1/10 to 1/100 | A person in a street |
| *Uncommon* | 1/100 to 1/1000 | A person in a village |
| *Rare* | 1/1000 to 1/10000 | A person in a small town |
| *Very rare* | Less than 1/10000 | A person in a large town |

Complications that occur most often include:

- increased vaginal discharge (very common);
- erosion or abrasion of vaginal skin (common);
- vaginal bleeding (common);
- discomfort (common – often associated with pessary changes);
- pessary expulsion (common); and

- new bladder and bowel symptoms (common – these may include occult stress urinary incontinence due to reduction of prolapse, or urgency for voiding or defecation, urinary retention/obstructed defecation due to the pressure effects from the pessary).

Less common and serious complications include:

- vaginal ulceration (uncommon, but requires biopsy if it fails to heal);
- difficulty with removal (uncommon for a ring pessary, more common for others);
- infection (uncommon);
- incarceration (uncommon – where the pessary is displaced from its original position and becomes embedded in the vaginal or cervical tissues); and
- fistula (rare but serious).

## Pessary fitting

If a woman chooses a trial of pessary once treatment options for prolapse have been described and discussed, and informed consent obtained, she will need assessment to confirm her suitability for this option. If she still wishes to proceed, a suitable pessary will be fitted according to the clinical practice pathway (p. 13) and pessary choice algorithm (p. 16).

## Ongoing management

### Pessary review – time scales and changes

It is generally agreed that there should be a review appointment or follow-up check 4–6 weeks after the initial pessary fitting, but this varies according to local practice, availability of telephone support, type of pessary and whether the pessary is self-managed. The evidence for frequency of follow-up is not conclusive.

Good practice for subsequent follow-up appointment intervals whilst a pessary is in use is considered to be no longer than every 6 months, but this can be extended if the pessary is successfully self-managed.

Recommendations are suggested for individual pessaries in the pessary fitting and removal section (Appendix 5).

A new pessary is required when the pessary is showing signs of wear, such as cracks or splits, smells, or is not controlling the symptoms of pelvic organ prolapse sufficiently and in accordance with any specific manufacturer's instructions.

At each visit the control of symptoms and the fit of the pessary should be assessed. The pessary should be removed, and the vaginal walls, and if present, the cervix, inspected using a speculum. The same pessary may be washed and replaced if it does not show signs of wear, or a new one inserted, which may be the same type and size, or an alternative if the previous one is not completely satisfactory.

All clinical findings, and the size and type of pessary inserted, should be clearly documented.

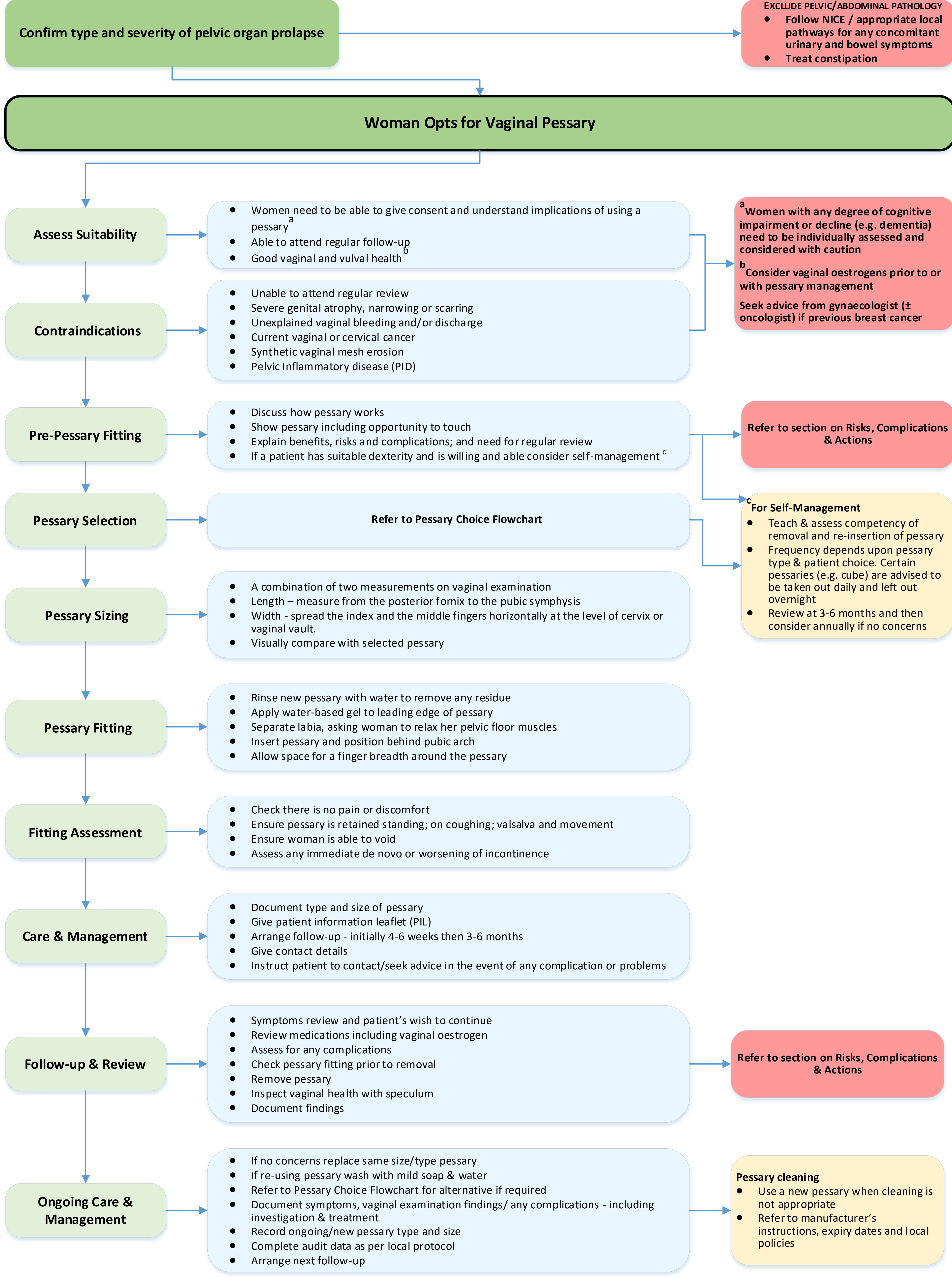
## Use of vaginal (topical) oestrogen

Vaginal atrophy manifests as thinner, drier, more fragile and less-elastic vaginal tissue, and may occur when there is a reduction of circulating oestrogen, such as after the menopause or during breast-feeding. As an intravaginal device, a pessary sits against the vaginal walls and may cause abrasions. A vaginal pessary can excoriate the atrophic skin, causing discomfort. To minimise the effect of this, a woman with vaginal atrophy considering pessary use, including one who is on systemic hormone replacement therapy (HRT), can be prescribed vaginal oestrogen prior to, or during, pessary use. Vaginal oestrogen is administered as a cream, a vaginal tablet or pessary, or as a vaginal ring containing a controlled release delivery system lasting 3 months.

Vaginal atrophy is likely to respond to oestrogen treatment within 3 months, but an individual's response, local practice and specific products may vary. A follow-up vaginal examination will determine whether the vaginal skin has improved sufficiently to allow pessary use with or without ongoing oestrogen support.

For a woman where systemic HRT is contraindicated, vaginal oestrogen can also be considered, after seeking advice from a healthcare professional with expertise in the menopause. A woman with vaginal dryness may also use moisturisers and lubricants alone or in addition to vaginal oestrogen. Pessary practitioners should be aware of the recognised contraindications and cautions relating to the use of vaginal oestrogen which are clearly stated in the NICE Clinical Knowledge Summary.[8]

# Pessary use for prolapse: clinical pathway



# Vaginal Pessary – Risks, Complications and Actions

**Vaginal Pessary – Risks, Complications and Actions**

- Mild vaginal discharge
  - Reassurance if not bothersome
- Malodourous or heavy vaginal discharge
  - Consider treatment to maintain normal acidic pH (e.g. vaginal gel/oral probiotics)
  - Vaginal swab to exclude infection
  - Treat with antibiotics if bacterial vaginosis or infection is suspected
  - Remove/provide new pessary
- Vaginal bleeding due to abrasion/erosion/ulceration
  - Remove pessary until the vagina heals (2–4 weeks)
  - Offer vaginal oestrogens to aid vaginal tissue healing
  - If the underlying cause is a tight pessary replace with smaller pessary
  - Vaginal biopsy should be considered when ulcerations do not heal
- Unexplained vaginal bleeding
  - Consider trans-vaginal/pelvic ultrasound if uterus present
  - Referral for specialist advice/treatment
- Pain or discomfort
  - Remove pessary
  - Re-size pessary/consider different type
- Urinary incontinence (*de-novo* or increase)/voiding difficulties/urinary retention
  - Remove pessary and reassess voiding function
  - Re-size pessary/consider different type
  - Follow NICE/local pathway for treating occult stress urinary incontinence
  - Treat suspected urinary tract infection with antibiotics
- Constipation or difficulty emptying bowel
  - Treat constipation
  - Remove pessary and reassess bowel function
  - Re-size pessary/consider different type
- Difficult removal due to granulation of neglected pessary
  - Consider inserting vaginal oestrogen cream or lubricant and leave *in situ* for 20–30 mins before trying to insert a finger behind the pessary and gently rotating it before attempting removal
  - Alternatively send home with vaginal oestrogen cream to use nightly and try again in 1–2 weeks
  - Cutting the pessary *in situ* in clinic might be tried before considering examination under anaesthetic (EUA) and removal in theatre.
- Other severe complications will require pessary removal and referral for specialist advice/treatment
  - Impacted/embedded pessary +/- fistulae
  - Cervical incarceration
  - Suspected vaginal or cervical cancer
  - Septicaemia

## Pessary choice

Vaginal pessaries can be broadly divided into two categories:

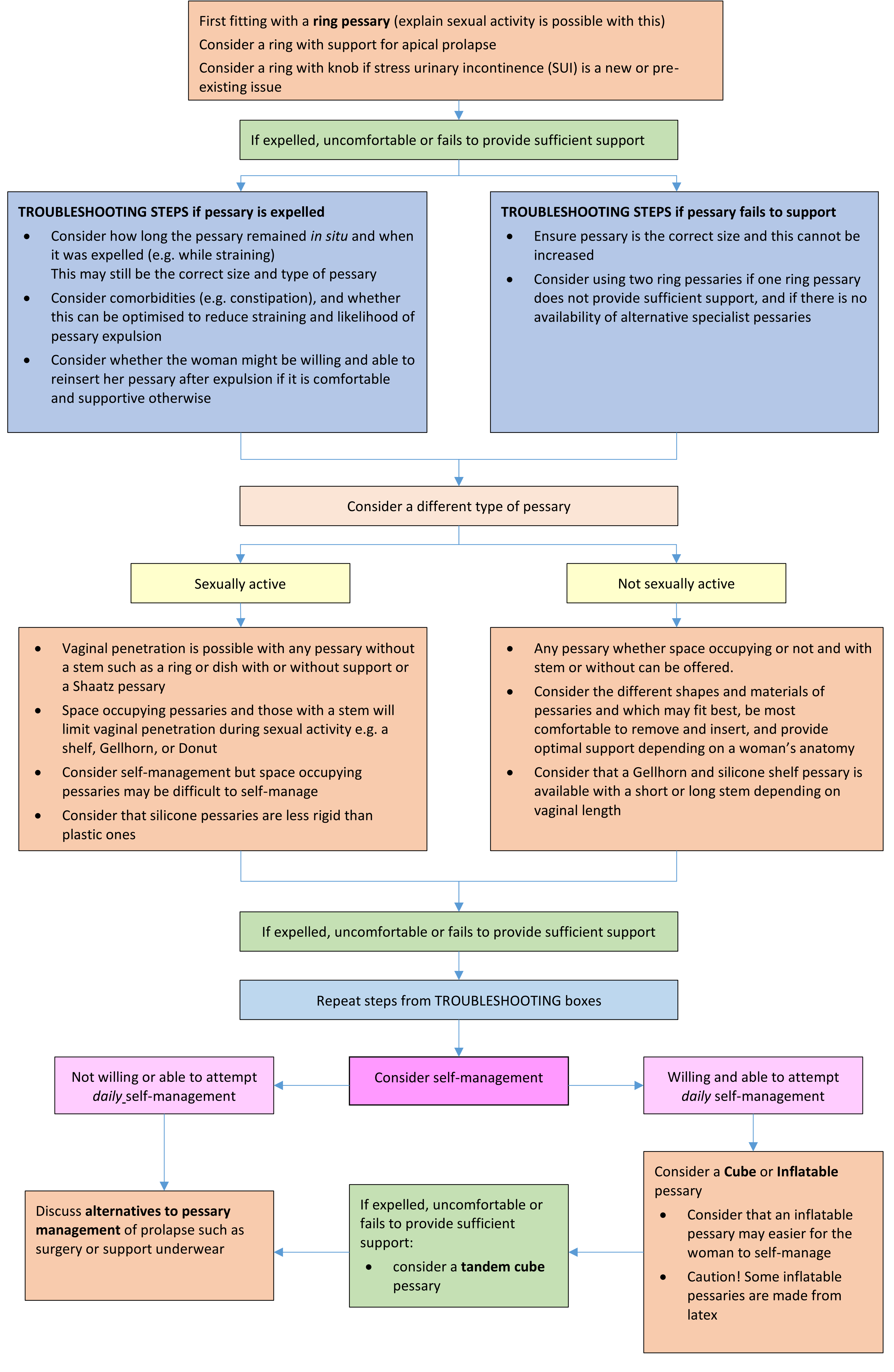
- support pessaries (ring, ring with support, Gehrung, Hodge and Shaatz)
- space-filling pessaries (shelf, Gellhorn, Donut, cube and inflatable).

This document will refer to pessaries by name, not category.

Pessaries vary in size, shape and material. For all pessaries employed in routine clinical practice, detailed information about the shape, fitting process and any indications for use specifically related to the design are included in Appendix 5.

Information about the fitting and removal of the most commonly used pessaries is provided within the pessary choice flowchart on page. 16.

# Pessary Choice Algorithm



## Additional considerations for pessary use in prolapse

### Pessary self-management

It is recommended that any woman who has been assessed, found suitable, and has agreed to try a vaginal pessary, should be offered the possibility of self-management if this option is supported and available. This puts the woman in control of managing her own condition, to suit her lifestyle.

To self-manage successfully, the woman needs to be confident about inserting, removing and cleaning the pessary, and be able to order a new one, book and attend follow-up appointments, and ask for advice as needed. All the elements of successful self-management can be taught by the pessary practitioner with verbal information given together with written guidance, including contact details in case an earlier appointment is required.

### Patient information

Best practice in pessary use for pelvic organ prolapse requires a woman to have access to and receive relevant, reliable and appropriate information about the pessary management process, including how to manage common complications and when to seek additional help. Tips for optimal pessary practice and relevant illustrations may be very helpful and increase the likelihood of continuation and satisfaction. This guideline document includes a Patient Information Leaflet (Appendix 6).

### Monitoring and audit

It is expected that the impact of this guideline will lead to a more consistent pessary provision across the UK and in turn an opportunity to improve the collection and audit of pessary related data. The guideline group recommends that data is collected and collated for:

- patient satisfaction using a reliable, replicable and simple Patient Reported Outcome or Experience Measure (PROM or PREM), such as the Patient Global Impression of Improvement (PGI-I)
- pessary effectiveness using a PROM or PREM
- review times for follow-up and replacement
- self-management: offered; declined; accepted; success
- pessary data: type and cost

## Appendix 1 – The UK Clinical Guideline Group for the use of pessaries in pelvic organ prolapse

Table 1: Group Membership

| Name | Profession and location | Role in guideline preparation | Professional associations |
| --- | --- | --- | --- |
| Kate Lough (Chair) | Physiotherapist researcher<br>Nursing, Midwifery and Allied Health Professional Research Unit<br>Glasgow | Clinical practice advisor<br>Overall editing of guideline | Chair of Pelvic, Obstetric and Gynaecological Physiotherapy (POGP) |
| Ruth Hawkes | Chartered Physiotherapist specialising in Pelvic Health<br>Private Practitioner<br>Cumbria | Clinical practice advisor<br>Lead for the subcommittee for Patient Information (Appendix 6) | Chair Education Subcommittee of POGP |
| Claire Brown | Clinical Specialist Physiotherapist<br>Cambridge University Hospitals NHS Foundation Trust | Clinical practice advisor<br>Lead for the subcommittee for Training guidelines (Appendix 4) and development and reporting of the multi-disciplinary pessary survey | Full Member POGP |
| Angela Rantell | Lead Nurse Urogynaecology, King's College Hospital, London | Clinical practice advisor<br>Pessary types (Appendix 5) | Nursing committee – International Continence Society (ICS)<br>Chair of Nursing and Midwifery SIG for IUGA |
| Lucy Dwyer | Clinical Nurse Specialist Urogynaecology<br>The Warrell Unit, St Mary's Hospital<br>Manchester University NHS Foundation Trust | Clinical practice advisor<br>Pessary choice algorithm flow-chart<br>Pessary types (Appendix 5)<br>UKCS Service Evaluation Project | |

| Name | Profession and location | Role in guideline preparation | Professional associations |
|---|---|---|---|
| Ellie Stewart | Gynaecology Matron and<br>West Suffolk NHS Foundation Trust | Clinical practice advisor<br>UKCS Service Evaluation Project | Royal College of Nursing |
| Kate Welford | Advanced Nurse Practitioner (Urogynaecology)<br>UCLH NHS Foundation Trust<br>London | Clinical practice advisor Subcommittee for Patient Information (Appendix 6) | |
| Sharon Johnson | Clinical Nurse Specialist Urogynaecology<br>Salford Royal NHS Foundation Trust | Clinical practice advisor | |
| Kate Anders | Clinical Nurse Specialist<br>Lead Nurse, Urogynaecology, Ashford & St Peters Hospital Foundation Trust, St Peters Hospital, Guildford Road, Chertsey, Surrey | Clinical practice advisor Subcommittee for Training guidelines (Appendix 4).<br>Clinical pathway algorithm<br>Flow chart for pessary fitting and ongoing management | Secretary – United Kingdom Continence Society (UKCS) |
| Fatima Goulter | Clinical Nurse Specialist Urogynaecology, Edinburgh | Clinical practice advisor | |
| Veenu Tyagi | Consultant Urogynaecologist<br>NHS Greater Glasgow and Clyde | Clinical practice advisor<br>Pessary choice algorithm flow-chart<br>Pessary fitting demonstration videos | Scottish Pelvic Floor Network |
| Jennifer Davies | Consultant Obstetrician and Gynaecologist<br>Wrightington Wigan and Leigh NHS Teaching Hospitals Foundation Trust | Clinical practice advisor Overall editing of guideline<br>Subcommittee for Patient Information (Appendix 6) | Vice Chair – British Society of Urogynaecology (BSUG) IT Committee |
| Clive Spence-Jones | Consultant Urogynaecologist<br>Whittington Hospital, London | Stakeholder representative | IT Committee – British Society of Urogynaecology |

| Name | Profession and location | Role in guideline preparation | Professional associations |
|---|---|---|---|
| Julia Wilkens | Consultant Urogynaecologist<br>Edinburgh | Clinical practice advisor<br>Pessary images | |
| Naz Abbas | Clinical Research Fellow, The Warrell Unit, St Mary's<br>Hospital, Manchester University NHS<br>Foundation Trust | Clinical practice advisor Subcommittee for Training guidelines (Appendix 4)<br>Pessary choice algorithm | UKCS |
| Georgia Smith | Senior Registrar in Obstetrics & Gynaecology, Urogynaecology ATSM<br>Gloucester Royal Hospital | Overall editing of guideline.<br>Clinical practice advisor<br>Subcommittee for Training guidelines (Appendix 4) | |
| Roland Morley | Consultant Urologist<br>Imperial College Healthcare NHS Trust | Guideline production advisor | Chair – United Kingdom Continence Society (UKCS) |
| Jennie Grainger | Consultant Colorectal Surgeon<br>Countess of Chester NHS Trust | Clinical practice advisor<br>Subcommittee for Patient Information (Appendix 6) | Webmaster and External Affairs Officer – The Pelvic Floor Society |
| Avril McDowell | Pessary User | Subcommittee for Patient Information | |
| Di Tilston | Pessary User<br>Physiotherapist | Subcommittee for Patient Information (Appendix 6) | |
| Lucy Brett | Lay member | Subcommittee for Patient Information (Appendix 6) | |

In addition, there were two stakeholder representative members included from the outset:

- Chris Harding, Consultant Urological Surgeon, Freeman Hospital, Newcastle-upon-Tyne; Chairman, European Association of Urology Guidelines Panel (Female Non-Neurogenic Lower Urinary Tract Symptoms); and immediate past Chairman, British Association of Urological Surgeons subsection of Female, Neurological and Urodynamic Urology

- Professor Jo Booth, Professor of Rehabilitation Nursing & Ageing Well Research Group Lead, immediate past Chair of the Association for Continence Advice Education Committee

All members were involved in general discussions at committee meetings which were undertaken both virtually and face to face.

Subcommittees, as indicated in the table, discussed and formulated various sections of the guideline.

The full guideline was compiled and edited by Kate Lough, assisted by Jennifer Davies and Georgia Smith.

## Target population preferences and views

The James Lind Alliance Pessary Use for Prolapse Priority Setting Partnership was set up to work with women with prolapse, and their partners, caregivers and clinicians to identify uncertainties about the use of a pessary for the management of symptomatic prolapse. It published the Top Ten shared priorities for future research in pessary use for prolapse in September 2017:[1]

1. How might a pessary affect sexual activity?
2. Do pessaries have an effect on the psychological well-being of women?
3. What is important for a pessary self-management programme?
4. What are the risks and complications of pessary use for prolapse?
5. Are pessaries effective as a long-term treatment for prolapse?
6. What is the best way to assess what type and size of pessary to use?
7. What is the best way to minimise and treat vaginal discharge caused by pessaries?
8. Does pessary use in prolapse have a positive impact on physical activity?
9. When should oestrogen cream be used with a pessary?
10. What is the ideal training to be a 'qualified' pessary practitioner?

## Patients

The three lay members of the group were consulted and advised about patient views. Further patient views were obtained in the final review as described below.

## Healthcare professionals

At the start of the guideline development process, a multi-professional survey was conducted with replies from more than 900 healthcare professionals including nurses and midwives, physiotherapists, gynaecologists, urologists, colorectal surgeons, general practitioners and others. This addressed current pessary practice, the availability and type of training and continuing professional development in pessary use.[9]

The guideline group considered the results of these reviews to determine the content of the final guideline and to inform the final recommendations.

## External review

Once the draft guideline was completed, feedback from the public, healthcare professionals and stakeholders was requested to ascertain that the guidance for pessary use and training were acceptable and feasible to implement. Feedback on the patient information leaflet was obtained regarding readability and the scope of the content.

The draft documents were sent to the following stakeholders for comments:-

- British Association of Urological Nurses (BAUN)
- International Urogynecological Association (IUGA)
- Pelvic Obstetric and Gynaecological Physiotherapy (POGP)
- Scottish Pelvic Floor Network (SPFN)
- The Association of Continence Advice (ACA)
- The British Society of Urogynaecology (BSUG)
- The Pelvic Floor Society (TPFS)
- The Royal College of Nursing (RCN)
- The Royal College of Obstetricians and Gynaecologists (RCOG)
- The United Kingdom Continence Society (UKCS)
- Pessary users

A questionnaire was developed to gather feedback for all sections of the guideline and patient information which is reproduced at the end of this appendix.

The following information was amended and added to the guideline once comments were received.

- Terminology was amended to be more consistent throughout the document, and “pelvic organ prolapse” was used in preference to “vaginal prolapse”
- The layout of the guideline was altered to make the clinical guidance section clearer and easier to navigate
- Clinical guidance within the document and in the clinical algorithms was made consistent
- Additional clinical considerations were added to the caution and contraindication sections

- Information about diversity and inclusion, impact and the mechanism for receiving feedback following launch was added
- Illustrations were added to the patient information section
- Copyright information was added
- Changes were made to the training document, in particular the logbook to make the training process and acquisition of competencies more robust, and easier to implement across different training situations. This included the addition of a supervision section and a self-assessment table to record progress.

## Funding

Funding was provided by the following organisations for the purposes described. The funding bodies did not influence the content of any of the documents.

United Kingdom Continence Society Small Grant Scheme (£5000) to fund:

- Service evaluation to determine where and who delivers pessary care in the UK. Awarded to E. Stewart and L. Dwyer on behalf of the Pessary Guideline group[10].
- Travel expenses for Pessary Group Meeting with all relevant stakeholders 11/11/19 in London

Chartered Society of Physiotherapy (£8000) to fund:

- Multi-professional survey[9]
- Emailing survey to other health care professionals
- Venue/hospitality for Pessary Group Meeting with all relevant stakeholders 11/11/19 in London
- Travel Expenses for three POGP members to attend 11/11/19
- Artwork /illustrations /images for the Patient Information Leaflet

All group members provided input voluntarily without remuneration except in the form of travel expenses for the face to face meeting midway through the guideline preparation.

## Competing interests

No member of the group had any competing interests.

Figure 1: Stakeholder feedback questionnaire

# UK Clinical Guideline for best practice in the use of vaginal pessaries for pelvic organ prolapse

Developed by members of The UK Clinical Guideline Group for the use of pessaries in vaginal prolapse representing UKCS, POGP (a professional network of the CSP), BSUG, ACA, SPFN, The Pelvic Floor Society, RCOG, RCN and pessary users.

Funded by grants provided by UKCS and CSP (POGP)

# Review document

Thank you for agreeing to review this document in its late draft stage ahead of launch and publication March 2021.

Please answer the questions in the table below or put not applicable (N/A) if you feel that they do not apply to you.

The UK Clinical Guidance Group would be very grateful if your responses could be received by the week beginning 25th January 2021 and sent to the linked email address.

| Question | Response | If not please suggest ways to improve clarity or content |
|---|---|---|
| Is the language used easy to understand? | | |
| Is this document suitable for all level of healthcare professionals? | | |
| Is this guideline suitable for patients to read in full and should it be? | | |
| Do the illustrations improve the clarity of the document and are they easy to understand? | | |
| Do you broadly agree with the aims of the guideline? | | |
| Are the indications, contraindications and complications sections clear? | | |
| Is the process clear to follow and logical? | | |
| Are all the sections easy to follow and logical? | | |
| Could the pathway charts be used in clinic areas if printed off? | | |
| Could the pessary choice pathway be used to inform and help a woman choose which pessary is best for her? | | |
| Is this guidance suitable for all pessary provision in all healthcare areas? | | |
| Are all the standards logical and clear? | | |
| Can the training document be tailored and used by all practitioners of different levels of training and experience? | | |
| What would be the optimal format for this training standards section? | | |
| Is it clear how to choose and fit each pessary type? | | |
| Do the images indicate how to hold and fit the pessaries clearly? | | |

| | | |
|---|---|---|
| Is the language right for a woman seeking information for pessary use for prolapse? | | |
| Do the images in the Patient Information section clearly show prolapse and how a pessary sits vaginally when in place? | | |
| Do the FAQs cover all the questions that might be asked? | | |

**Any other comments? Please add below**

## Appendix 2 – Evidence informing the best practice in the guideline

The sources of evidence and information to support the clinical guidance recommended in this guideline were drawn from published systematic reviews, the 6th International Consultation on Incontinence[11], the evidence cited by NICE NG123[12] and national and international consultation and guidance publications (Table 2; p. 32). Two projects funded for this guideline added new information about pessary provision and practice in the UK.[9,10] Best practice not informed by available evidence was determined through consensus discussions with the members of the multidisciplinary guideline group.

Overall the evidence informing pessary use for pelvic organ prolapse is considered to be of low to very low strength with the majority of included studies being internationally conducted observational cohort studies with varying lengths of follow-up from centres with specialist pelvic organ prolapse management expertise. The small number of randomised controlled trials (RCTs) involving pessaries limits the confidence that can be had in the evidence for pessary use for prolapse.

This guideline supports the recommendation from NICE that a pessary should be considered as a non-surgical option for a woman with symptomatic prolapse. The best available evidence indicates that a pessary is an effective and satisfactory non-surgical management option for symptomatic pelvic organ prolapse with a low risk of complications. If correctly and comfortably fitted, many women will continue to use a pessary. Evidence indicates that the stage of prolapse and type of pessary does not affect the success of the intervention.

Overall, the research studies conducted suggest that:

- Younger, sexually active women are less likely to opt for a pessary although the reasons remain unidentified, and detailed descriptions of the components of the intervention are not clear.
- Bothersome side effects and a desire for surgery are the most likely reasons for discontinuation of pessary use.
- Significant complications are not common. Complication rates of around 12% for milder problems such as bleeding or vaginal erosions are quoted in the included studies.

- An unsuccessful pessary fitting is likely to occur within 2–4 weeks of initial fitting, and up to three trials of different pessary types or sizes are not uncommon.
- No pessary is proven to be better than another – although the majority of pessaries used in the studies were ring pessaries.
- No pessary is more suitable than another for a prolapse affecting a particular compartment.
- Approximately 60% of women are likely to be satisfied with a pessary for symptomatic prolapse after a year. The long-term rates are less clear but may remain at around 50% between 1 and 5 years.

The guideline does not include references to individual studies to suggest evidence for clinical practice, but some references are included to provide further information for those who are using the guideline in clinical practice and to help in decision-making for treatment pathways for symptomatic pelvic organ prolapse.

## Evidence relating to the use of vaginal (topical) oestrogen

The evidence for the use of topical oestrogen in conjunction with vaginal pessaries is limited. However, vaginal atrophy is recognised as a relative contraindication to pessary use and there is evidence of a beneficial effect on vaginal atrophy with locally applied oestrogen. A systematic review confirmed that topical oestrogen administration is effective for the treatment of vaginal atrophy and seems to decrease complaints of overactive bladder and urinary incontinence but that the potential for vaginal oestrogen in the prevention as well as treatment of pelvic organ prolapse needed further research.[13]

A consensus statement from the British Menopause Society in 2018 concluded that local vaginal oestrogen could be used for as long as it was needed[14] and NICE guidance (NG23 2015) stated that there was no risk of hyperplasia and therefore no need for endometrial surveillance or additional progestogen for endometrial protection with the current topical oestrogen preparations in use.[15] The BMS consensus statement concluded that the advice offered by NICE was supported by the Cochrane Database Review (2016).[16]

## Evidence relating to Patient Information

Shared decision making is considered to be a central tenet of patient care and in order to inform shared decision making, it is essential that both patient and clinician have a clear understanding of the risks and benefits of all treatment options. Patient information leaflets are essential to allow a patient to make a truly informed choice about treatment. It is well recognised that it is important to provide written information to support verbal information given in a clinic as the level of retention of spoken information is poor with between 40% and 80% being forgotten immediately and only about half of what is remembered being remembered correctly.[17] Retention is improved by the provision of written information and can reach 80% if given as pictographs.

Published studies have indicated that a lack of information and a lack of knowledge can contribute to women with prolapse delaying seeking healthcare support.[18,19]

There is a lack of consensus about the benefits of patient decision aids. Although the Cochrane review concluded that decision aids could help people to feel more knowledgeable and better informed,[20] Brazell *et al* did not find that a decision aid reduced decisional conflict about treatment choice in women with prolapse.[21] Decision aids available for a woman seeking information about management of prolapse relate to treatment options about surgical choices.[22] Although the use of non-surgical measures such as vaginal pessaries is mentioned, these are not compared with surgical options to aid decision making.

Table 2 : Evidence source table

| Document | Search criteria | Search year | Included studies | Grading | Comments |
|---|---|---|---|---|---|
| Systematic scoping review - <br>2020 <br>Lough[23] | Medline, Cochrane library databases (Cochrane Database of Systematic Reviews – CDSR, Health Technology Assessment – HTA, Database of Abstracts of Reviews of Effects – DARE, Cochrane Central Register of Controlled Trials – CENTRAL), CINAHL (EBSCO), PsycINFO (EBSCO) <br>No study design restriction | 2000–2016 <br>Update April 2018 | 24 studies following critical appraisal. <br>3 RCTs <br>17 observational cohort <br>2 qualitative <br>2 cross-sectional | N/A | 3 UK studies |
| Literature review <br>2019 <br>Dwyer[24] | AHMED, MEDLINE including in-process and other non-indexed citations, BNI, CINAHL, and EMBASE <br>Search terms: "pessary", "confidence", "training", "prolapse", "healthcare professional" and "competency" | No date restrictions. <br>Included studies 2001–2017 | 13 studies: <br>10 survey method <br>1 pilot RCT <br>1 Consensus method <br>1 observational cohort | N/A | Relevant to practitioner training |
| NG123 <br>NICE <br>2019[12] | Medline, Embase, Cochrane library <br>Search terms relating to conservative management options for prolapse | 1947–2017 | 10 studies, 2 RCTs related to pessaries | Low and Very low | |
| Incontinence – 6th Edition <br>2017 <br>ICS/ICUD[11] | Not specified for pessary section but ICUD recommends previous 10 years – Medline, Embase, Cochrane library, Biosis, Science citation index and peer reviewed journals for 3 months prior | Not known | 17 studies | Level of evidence 2 and 3 <br>No recommendation grading offered | 3 UK studies |

| Document | Search criteria | Search year | Included studies | Grading | Comments |
|---|---|---|---|---|---|
| Systematic review<br>De Coelho<br>2016[25] | PubMed, LILACS, SciELO<br>Pelvic Organ Prolapse AND Pessaries AND Quality of Life" OR "Pessary AND Quality of Life" OR "Pessaries". | Up to 2015 | 7 studies including 1RCT | N/A | Included papers related to quality of life using a validated questionnaire<br>2 UK studies |
| Pessaries (mechanical devices) for managing pelvic organ prolapse in women<br>Cochrane<br>Bugge *et al* 2020[26] | Search strategy developed for the Cochrane Incontinence Review Group applied to the Incontinence Group Specialised Register of controlled trials (CENTRAL), MEDLINE, CINAHL, and handsearching of journals and conference proceedings)<br>RCTs and Quasi RCTs | Up to January 2020 | 4 RCTs | Very low and low to moderate | |

Two new projects were funded by the UKCS and CSP for this guideline. At the time of submission, the working group was called The Pessary Use for Vaginal Prolapse UK Guidance Group.

## 1. A Service Evaluation to Determine Where and Who Delivers Pessary Care in the UK

Dwyer L., Stewart E. & Rajai A. for The Pessary Use for Vaginal Prolapse UK Guidance Group[10]

Background:

Pessaries offer effective conservative management for symptoms of pelvic organ prolapse and are frequently used in the UK. Previous publications have highlighted a lack of evidence-based pessary guidelines. There is also a dearth of evidence regarding who UK pessary practitioners are and the training received.

Method:

A Freedom of Information (FOI) request was sent to 167 healthcare organisations in the UK. Requested information included the number of pessaries inserted or changed, the grade and profession of pessary practitioners and training requirements at the organisation.

Results

Responses were received from 128 organisations. At 72% of organisations, pessary care was provided by both doctors and nurses of varying grades. At 18% of organisations either solely doctors or solely nurses provided pessary care. At the remaining 9% there was a multidisciplinary approach to pessary care. At 3 hospitals (2%), unregistered healthcare professionals provided pessary care.

At the majority of organisations, respondents undertook supervised practise to gain skills in pessary management. Additional methods of training cited were learning through observation or achieving set competencies. 26% received didactic training. At 21% of organisations there were no training requirements.

Conclusions

At most organisations, there was a multi-disciplinary approach to pessary care. It is questionable whether unregistered healthcare professionals should be delegated responsibility for pessary care. A standardised approach to pessary practitioner training is advocated to ensure women receive safe, evidence-based pessary care.

## 2. A Multidisciplinary UK Survey on Current Pessary Practice

Brown C..A., Pradhan A. & Pandeva I. for The Pessary Use for Vaginal Prolapse UK Guidance Group[9]

Background:

Symptomatic vaginal pelvic organ prolapse (POP) affects 6–28% of women and significantly impacts on their quality of life. Pessaries for POP are used by three quarters of clinicians as a first line treatment, however current clinical use in the UK is unknown and there is a lack of clinical guidance or training.

Methods:

A 19-question anonymised electronic survey was sent to members of the nine professional bodies believed to be delivering pessary care in the UK.

Results:

Of 917 respondents, 403 (246 nurses, 134 doctors and 22 physiotherapists and one other profession) currently deliver pessary care. PVC/vinyl ring, silicone ring, Gellhorn and shelf pessaries are most popular, and are used frequently by 93% of respondents. 62% of those currently providing pessary care, and 70% of those that do not, have requested pessary training in the future. The most highly rated method for previous and future training is shadowing another clinician (irrespective of respondent profession). One in three respondents receive no ancillary support and nearly one in seven (predominantly nurses) report no cross-cover arrangements leaving their patients unsupported while they are away.

Conclusion:

Service provision, support and pessary training vary greatly reflecting a lack of guidance and evidence. There is a clear rationale – and appetite – for a UK pelvic organ prolapse pessary guideline and a standardised multi-professional pessary training model.

## Future Research

The Guideline Group strongly support future research to address the gaps identified by the James Lind Alliance pessary use for prolapse priority setting partnership[1]. Specific research questions related to the top ten priorities might include:

- What is the best way to measure the effectiveness of a pessary used to treat prolapse?
- Does a pessary used for prolapse have an effect on the severity of the prolapse over time?
- What is the optimal management pathway for a woman using a pessary to maintain effectiveness, reduce the likelihood of dissatisfaction and prevent complications?
- Does the type of pessary make a difference to the outcome of the treatment?
- Who should be offered self-management, and for how long?
- What are the experiences of women who use a pessary?

## Appendix 3 – Areas of pessary care provision that may create barriers and variation in clinical practice

The Guideline Group have identified areas of pessary care provision that may create barriers and differences in clinical practice. Potential solutions are suggested relating to referral pathways, women with previous pelvic organ prolapse surgery, the availability of information, training in pessary management as well as data collection.

Problem: Access and referral pathways to pessary provision for women vary and may not be timely.

Potential Solution: *Clearer routes for self-referral or onward referral for non-surgical management of pelvic organ prolapse symptoms.*

Problem: Women who have had previous surgery for prolapse do not always have an identified route to pessary provision.

Potential Solution: *Better understanding of the vaginal anatomy post-surgery may reduce the risk of pessary failure for a woman seeking further management of prolapse symptoms.*

Problem: Reliable and consistent sources of information about pessaries for women are hard to find.

Potential Solution: *Widespread dissemination of a guideline and patient information across all healthcare areas in accessible formats. Create links with GPs to help develop their knowledge of prolapse and the recommended pathways.*

Problem: Variability of initial pelvic organ prolapse management and knowledge between healthcare providers

Potential Solution: *Additional training for those clinicians who are regularly performing vaginal examinations to enable onward referral as required for further tests and more timely provision of appropriate early prolapse management that may include pelvic floor muscle training and pessary provision.*

Problem: Inconsistent and variable access to self-management options for women in the UK in comparison with other countries with established self-management

programmes. Limited research on which to base evidence-based practice for this option.

Potential Solution: *Dissemination of the UK guideline with clear guidance on best practice for self-management. Include self-management information in resources for women. Additional training and information for existing pessary practitioners to increase their confidence in supporting self-management for women.*

Problem: Audit and data management of pessary use for pelvic organ prolapse is outdated, inconsistent and not mandatory.

Potential Solution: *Build a requirement for a change in the recording of pessary related data in women's notes and submitting to NHS data.*

Problem: Inconsistent use of vaginal oestrogen when pessaries are used in the management of prolapse.

Potential Solution: *Encourage participation in research to explore the risks and benefits of vaginal oestrogen for women with pessaries and improve recording of oestrogen provision in a woman's notes.*

Problem: Training and competencies for pessary practitioners are on an ad hoc, Trust by Trust basis and are not mandatory in order to provide a service.

Potential Solution: *A UK-wide flexible training framework to upskill those who are currently fitting pessaries but feel underqualified to offer a full pessary service, or to train new practitioners to an agreed level of competency.*

## Appendix 4 – Training Document

Clinicians offering pessary management must comply with their own professional standards to ensure that they are working within their own scope of practice and they receive training that is compliant with professional guidance.

Before undertaking any training in the use and management of vaginal pessaries, the clinician must have completed training in vaginal examination and be using this in clinical practice.

A baseline knowledge and experience should already be established and include:

- Clinical knowledge of anatomy and physiology of the pelvic floor complex
- Clinical decision-making skills and diagnosis
- Regular performance of vaginal examinations
- Informing women and gaining informed consent
- Communication with the MDT/local referral centres and following local guidelines
- Clinical governance issues including (i) managing unexpected effects (ii) safeguarding of adults (iii) chaperoning (iv) infection prevention/control (v) signposting to other agencies
- Some clinicians may have a knowledge of pelvic floor muscle assessment and can use this skill concurrently with prolapse management

### Self-Declaration

I declare that I have the pre-requisite baseline knowledge and experience to undertake this training. This is evidenced in my portfolio or in the requirements of my current job role.

Signed:

Date:

## Aims of the Training Document

This document aims to serve as a framework for clinicians who wish to achieve pessary skills by following the eight standards. It is designed to be flexible to facilitate the learning process and aims to standardise skill level. Consequently, this document may act as a personal logbook for the clinician to accumulate signatures to demonstrate their achieved competence in pessary care and prove fitness to practice. It is also recognised that this document could be tailored for clinicians who already have pessary skills. In addition, there are some pessary clinicians who are solely involved in removing and reinserting pessaries, without performing the initial assessment or fitting. The guideline group feel that such clinicians should be competent at Standards 1, 2 and 3 which are described below.

The woman should be informed that the practitioner is under training and being observed by their supervisor.

## Consent

Consent should be obtained after the woman is fully informed, involved in the discussion and reassured about the process of a vaginal examination. Enough time should be given for the woman to ask questions.

Information given should include:-

- the reason for the examination, including the use of a speculum and lubrication
- the duration of the examination
- discuss the positions that may be required during the examination
- discuss what may be expected of the woman, for example straining/bearing down and how to achieve this
- explain straining/bearing down during the examination may cause leaking or wind
- reassure that any pain/discomfort or bleeding experienced should be minimal and very temporary

After the examination, findings should be explained and all treatment options discussed.

## Competency Assessment

For each learning objective within the standards described, there is the opportunity for the pessary clinician to evidence their learning and clinical competence. An assessor may sign which level they deem the clinician to be practising at for each particular objective. The levels have been modified from Benner's Stages of Clinical Competence[27] and amalgamated with the RCOG Core Curriculum Sign off requirements[28] and are described as follows:

- **Level 1**: Novice (observed practice) – describes a clinician who is at the stage of observation. They observe another healthcare professional carry out a task related to pessary care.
- **Level 2:** Advanced Beginner (supervised practice) – describes a clinician who performs adequate pessary care under supervision.
- **Level 3**: Competent (independent practice) – describes a clinician who independently achieves each learning objective, whose practice is clearly underpinned by a sound understanding and knowledge base of pessary care.

We acknowledge that some clinicians have limited means for assessment so may demonstrate their clinical aptitude by other methodologies ('OM') such as attendance at a course, completion of an e-learning module or a reflective account of a particular case. We suggest that if a standard is being achieved with 'OM' there should be a minimum of three different types of evidence to support each standard.

## Standards

1. Removal and insertion of pessaries for routine changes

2. Knowledge of the indications and management involved in pessary care

3. Knowledge of how to manage complications of pessaries

4. Prolapse assessment

5. Assessment for fitting the first pessary

6. Knowledge of alternatives to pessaries

7. Pessary self-management

8. Reflective Practice

## General Expectations

The clinician should be able to adhere to local and national policies on chaperoning, safeguarding, consent and infection control procedures. This should be demonstrated throughout each standard.

## Standard 1: Removal and insertion of pessaries for routine changes

### Rationale

The pessary clinician will need to be able to remove and insert a pessary. This will include an examination of the vagina and cervix using a speculum to assess tissue quality before pessary insertion.

The pessary clinician needs to be competent in each type of pessary used in their individual clinical practice. It is the responsibility of the pessary clinician to dictate their own learning needs. This training document suggests that pessary removal and insertion at level 3 should be demonstrated at least three times. Demonstrating this skill three times is guidance only. Some clinicians may need more practice to be competent. It is unlikely the clinician will be competent in fewer than three demonstrations.

### Knowledge and Understanding

A competent pessary clinician should be able to demonstrate that they:

- Understand the rationale for removing a pessary
- Understand techniques available in order to remove pessaries
- Know how to insert a pessary and ensure a correct fit

### Learning outcomes

The competent pessary clinician will be able to:

- Communicate effectively throughout the procedure including demonstration of a pessary to a woman, explaining the benefits and risks, and allowing the patient to handle the appropriate pessary
- Prepare the environment
- Remove the current pessary
- Examine the vagina and cervix by using a speculum and check the health of the tissue
- Insert a pessary
- Test for correct fit of the pessary
- Assess for a new size if the current pessary does not provide a comfortable fit or if the prolapse is not supported
- Ensure clear documentation of size and type of pessary that has been fitted
- Know how to refer onwards if clinically indicated

## Standard 2: Knowledge of the indications for pessary use and management involved in pessary care

### Rationale

The pessary clinician will need to understand when a pessary can be offered for prolapse management, understand the different variety of pessaries and the level of care needed.

### Knowledge and Understanding

A competent pessary clinician should be able to demonstrate:

- An awareness of local and national policies for prolapse management
- A good knowledge of types of pessary available in their locality
- An understanding of the indication for onward referral when a pessary is no longer managing the prolapse symptoms or if a particular type of suitable pessary is available elsewhere

### Learning Outcomes

The competent pessary clinician will be able to:

- Introduce a pessary to a woman and explain the benefits and risks
- Describe different types of pessary on offer and the rationale for using the selected pessary
- Offer a woman pessary management in the short-term, such as an interim measure whilst considering/waiting for surgery or during pregnancy
- Reassure a woman that pessaries may be used successfully to manage prolapse in the long term
- Describe to a woman the aftercare and follow-up that is required for the pessary used
- Offer a woman the option of self-management of her pessary
- Educate a woman on when to seek medical advice or help when managing her own pessary

## Standard 3: Knowledge on how to manage complications of pessaries

### Rationale

The pessary clinician will need to understand how to manage a range of pessary related complications.

### Knowledge and Understanding

A competent pessary clinician should be able to demonstrate an understanding of:

- The possible complications related to fitting and trial of vaginal pessary device
- The process for reporting complications of pessary use
- How to deal with a range of complications
- Their clinical limitations of expertise and knowledge, and understand when an onward referral is needed

### Learning outcomes

The competent pessary clinician will be:

- Able to minimise the risk associated with fitting and trial of vaginal pessary device for pelvic organ prolapse
- Competent to perform a speculum examination
- Competent to undertake vaginal swabs
- Able to manage/advise about the use of vaginal oestrogen
- Competent in recognising complications and be able to set out a management plan for:-
    - abnormal vaginal discharge
    - vaginal infection
    - abnormal vaginal and vulval health e.g. atrophy/vaginitis/lichen sclerosus
    - vaginal or vulval abrasion/ulceration
    - unexplained vaginal bleeding
    - pain/discomfort
    - urinary symptoms including voiding difficulty, retention, incontinence
    - bowel symptoms including difficulty opening bowels, constipation or incontinence
    - difficult removal of pessary

# Standard 4: Prolapse Assessment

## Rationale

A clinician who is competent in all aspects of pessary care must first be able to accurately assess the presence, compartment involved and degree of pelvic organ prolapse. They should be able to communicate their clinical findings using a standardised method of reporting, such as the POP-Q system or other prolapse assessment methods. This clinical information will help to guide the clinician and/or healthcare team into choosing the most suitable form of pessary for the woman.

## Knowledge and Understanding

A competent pessary clinician should be able to demonstrate:

- Sound knowledge of female pelvic organ anatomy, including anatomy of the pelvic floor
- Knowledge of an appropriate recognised grading system for prolapse; being able to competently document their own clinical assessment and also interpret another clinician's findings
- Knowledge of techniques to exclude any pelvic or abdominal masses, which include abdominal and bimanual examination
- Techniques used to assess the presence, compartment and degree of prolapse using visual assessment and internal examination
- Awareness of their own limitations and the necessity of clinical support to ensure a complete assessment
- Proficiency in explaining their clinical findings to the individual woman and relate the results to her symptom profile, providing a clear plan for future management

## Learning Outcomes

The competent pessary clinician will be able to:

- Examine for presence of prolapse, assessing which compartments are involved and to what degree
- Record the clinical findings using POP-Q system or other prolapse assessment methods
- Explain the clinical findings to the woman
- Relate the clinical findings to the symptoms (and if this is not possible, to consider alternative investigations or onward referral)
- Use the clinical findings to plan ongoing care or referral
- Seek clinical support where necessary

## Standard 5: Assessment for fitting the first pessary

### Rationale

A clinician who is competent in pessary care will build on their initial assessment of a woman's prolapse, assess whether the woman is suitable for management with a pessary and then measure the vaginal dimensions to select a suitable type and size of pessary for the individual woman.

### Knowledge and Understanding

A competent pessary clinician should be able to demonstrate a knowledge of:

- Indications, contraindications and precautions when assessing and fitting pessaries for pelvic organ prolapse
- Signs, symptoms and management of problems occurring during initial pessary fitting for pelvic organ prolapse
- Local policies and procedures in assessing and fitting pessaries for pelvic organ prolapse, specific to the role of the clinician

### Learning outcomes

- Explain clearly to the woman the process of assessment for the first pessary and how it differs from an examination for prolapse
- Explain that there will be an initial trial period for the pessary, and more than one fitting may be necessary to find the most suitable pessary
- Assess for vaginal atrophy and organise treatment accordingly
- Perform an assessment of vaginal dimensions and select a pessary type and size to suit the clinical findings
- Insert the pessary
- Test for successful fit of the pessary
- Allow time for the woman to ambulate and pass urine after fitting
- Re-evaluate and reassess if the first pessary is not suitable or not retained
- Discuss pessary management advice e.g. sexual intercourse, support perineum when defecating, managing pessary dislodgement
- Ensure clear documentation of size and type of pessary that has been fitted

- Formulate a management plan for ongoing care and plan for safe change of the pessary in an appropriate environment e.g. self-management (if suitable), GP, or specialist clinic

- Seek clinical support where necessary

## Standard 6: Knowledge of alternatives to pessaries

### Rationale

The pessary clinician should be able to discuss alternative management options for prolapse, if a pessary fails or if a woman does not wish to have a pessary.

### Knowledge and Understanding

A competent pessary clinician should be able to demonstrate:

- An awareness of local and national policies on the alternatives to prolapse management available to a woman
- An awareness of the referral pathways so that a woman may explore her options and discuss alternative management
- An awareness of the risks of surgical management and indications to delay surgery, such as when a woman feels her family is not complete and would like to have further pregnancies

### Learning outcomes

The competent pessary clinician will be able to:

- Explore what is important to a woman with regards to her treatment goals
- Discuss the option of "doing nothing" and the risks where relevant
- Offer a woman follow-up when she has chosen to do nothing initially, and allow her to express any change in the management option chosen
- Discuss the option of pelvic floor muscle exercises and refer on if indicated
- Discuss the option of surgery to manage prolapse
- Explain to a woman that there are different types of surgery which may be offered to manage a prolapse, and this is dependent on the type of prolapse
- Explain to a woman that surgery carries risks, a failure rate and a risk of recurrence

## Standard 7: Pessary Self-Management

### Rationale

The pessary clinician will need to be able to offer pessary self-management when indicated.

### Knowledge and Understanding

A competent pessary clinician should be able to demonstrate:

- The skills to teach pessary self-management
- The knowledge of the types of pessary suitable for pessary self-management
- A clear pessary self-management service structure and contingency plan for out-of-hour complications and ongoing contact as required

### Learning outcomes

The competent pessary clinician will be able to:

- Demonstrate indications and contraindications for pessary self-management
- Communicate effectively the benefits of pessary self-management to a woman and how self-management can be used to suit the woman’s lifestyle
- Discuss the relevant anatomy, purpose of the pessary and location of the pessary once in situ
- Teach a woman how to insert and remove a pessary, including being able to demonstrate folding or handling the pessary and discussing different positions
- Discuss pessary care (removal frequency, cleaning procedures, lubrication and storage)
- Advise on sexual intercourse
- Communicate effectively to a woman warning signs and when to contact her pessary clinician
- Supply patient information to a woman to supplement pessary self-management care

## Standard 8: Reflective Practice

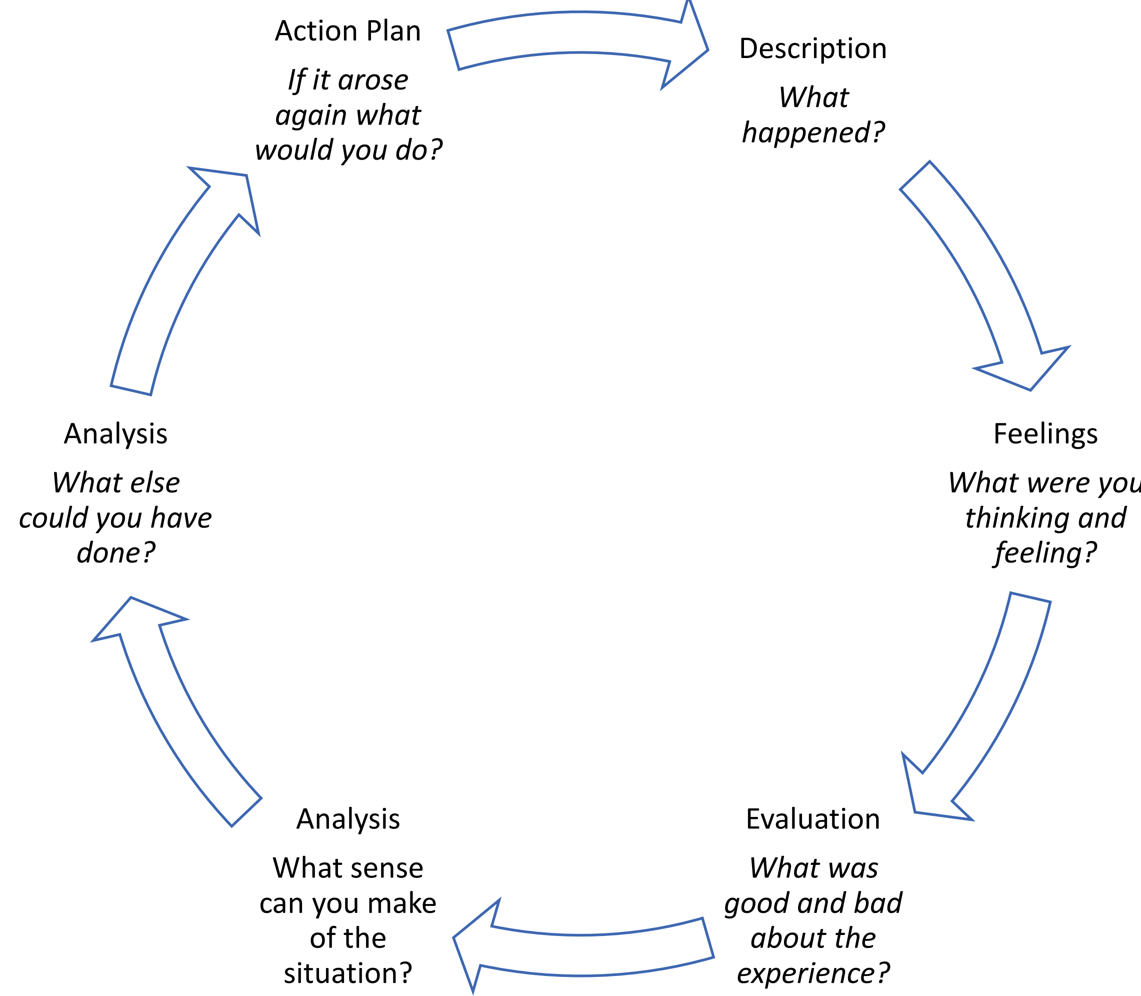
Reflective practice is the ability to reflect on one's actions to engage in a process of continuous learning.[29] It is an important source of personal professional development and improvement and is helpful in bringing together theory and practice. By using this concept in the training and development of vaginal pessary skills, it allows the learner to take a conscious look at their own clinical practice and experiences (both good and bad), how it affected them and add it to their existing knowledge base and thus reach a higher level of understanding. This can then lead to making positive changes or improvements that can be put into action in their everyday practice.

Suggested prompts to structure reflection:[30]

- What key things did you take away or learn from this experience/feedback?
- Was it a positive or negative experience?
- What were the consequences of your actions on the patient, others and yourself?
- What would you do differently, if anything, next time around?
- How has it impacted on your practice?
- Are there any changes you can apply to your practice?
- How can you apply this to meet any gaps in your knowledge, skills and understanding?

It is suggested the clinician completes a reflective account to document their learning process. Three reflective accounts have been suggested but the clinician should not be limited to this. The following pictogram may help to guide you during your reflective practice.

Figure 2: Engaging reflection in practice (Johns 2006)[29]



## Standards Logbook

The following pages are designed to provide you with a personal logbook to evidence your learning and competency as a pessary clinician. Please use this as a tool to enhance your learning, engaging with your supervisors to complete each level of the standards required.

## Supervision and Assessment

A supervisor is a healthcare practitioner who performs pessary care regularly as part of their normal job role requirements. This may be a practitioner who runs a pessary clinic, or a Consultant Gynaecologist or Registrar with a special interest in urogynaecology or prolapse management. This supervisor will be assessing the pessary care given by the trainee practitioner.

**For Level 1** – the supervisor is usually the person who is carrying out the pessary care, with the trainee practitioner observing how to complete the task.

**For Levels 2 and 3,** the trainee practitioner is the person who is carrying out the pessary care with the supervisor observing their practice. For Level 3, the supervisor is acting as an assessor only and should not have to provide any further input for that particular element of care. We recommend that throughout this logbook, the sign-off sections (Level 1, 2 and 3) are completed by a minimum of two supervisors to ensure each standard is assessed by more than one qualified practitioner.

## Supervisor details

Supervisors who are signing this document should complete their details in the table below:

| *Name* | *Position* | *Signature* | *Date* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| **<u>Standard 1:</u>** **Removal and insertion of pessaries for routine changes** | **LEVEL OF COMPETENCE ACHIEVED** | | | | | |
|---|---|---|---|---|---|---|
| | **Level 1** | | **Level 2** | | **Level 3** | |
| | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** |
| **Learning outcomes** | | | | | | |
| 1. Communicate effectively throughout the procedure including demonstration of a pessary to a woman, explaining the benefits and risks and allow the patient to handle the appropriate pessary | | | | | | |
| 2. Prepare the environment | | | | | | |
| 3. Remove the current pessary | | | | | | |
| 4. Examine the vagina and cervix using a speculum and check for the health of the tissues | | | | | | |
| 5. Insert a pessary | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 6. Test for correct fit of the pessary | | | | | | |
| 7. Assess for a new size if the current pessary does not provide a comfortable fit or if the prolapse is not supported | | | | | | |
| 8. Ensure clear documentation of size and type of pessary that has been fitted | | | | | | |
| 9. Know how to refer onwards if clinically indicated | | | | | | |

**Standard Achieved with Other Methodologies (please list below)**

| *Signature* | *Date* |
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| <u>**Standard 2:**</u><br>**Knowledge of the indication and management involved in pessary care** | **LEVEL OF COMPETENCE ACHIEVED** | | | | | |
|---|---|---|---|---|---|---|
| | **Level 1** | | **Level 2** | | **Level 3** | |
| | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** |
| **Learning outcomes** | | | | | | |
| 1. Introduce a pessary to a woman and explain the benefits and risks | | | | | | |
| 2. Describe different types of pessary on offer and rationale for using selected pessary | | | | | | |
| 3. Offer a woman pessary management in the short-term, such as when considering/waiting for surgery or during pregnancy | | | | | | |
| 4. Reassure a woman that pessaries may be used successfully to manage prolapse in the long term | | | | | | |
| 5. Describe to a woman the aftercare and follow-up that is required for the pessary used | | | | | | |
| 6. Offer a woman the option of self-management of her pessary | | | | | | |

| 7. Educate a woman on when to seek medical advice or help when managing her own pessary | | | | | | |
|---|---|---|---|---|---|---|
| **Standard Achieved with Other Methodologies (please list below)** | | | | | | |
| | | | | | | |

| *Signature* | *Date* |
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<table>
<tr><th rowspan="3"><u>Standard 3:</u><br><br>Knowledge on how to manage complications of pessaries</th><th colspan="6">LEVEL OF COMPETENCE ACHIEVED</th></tr>
<tr><th colspan="2">Level 1</th><th colspan="2">Level 2</th><th colspan="2">Level 3</th></tr>
<tr><th>Signature</th><th>Date</th><th>Signature</th><th>Date</th><th>Signature</th><th>Date</th></tr>
<tr><td colspan="7">Learning outcomes</td></tr>
<tr><td>1. Minimise risk associated with fitting and trial of vaginal pessary device for pelvic organ prolapse</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2. Be competent to perform speculum examination</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>3. Be competent to undertake vaginal swabs</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>4. Be able to manage/advise about the use of vaginal oestrogen</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

| | | | | | | |
|---|---|---|---|---|---|---|
| 5. Be competent in recognising complications and be able to set out a management plan for:-<br>• abnormal vaginal discharge<br>• vaginal Infection<br>• abnormal vaginal and vulval health e.g. atrophy/vaginitis/lichen sclerosus<br>• vaginal or vulval abrasion/ulceration<br>• unexplained vaginal bleeding<br>• pain/discomfort<br>• urinary symptoms including voiding difficulty, retention, incontinence<br>• bowel symptoms including difficulty opening bowels, constipation or incontinence<br>• difficult removal of pessary | | | | | | |
| **Standard Achieved with Other Methodologies (please list below)** | | | | | | |

| *Signature* | *Date* |
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| Standard 4:<br><br>Prolapse assessment | LEVEL OF COMPETENCE ACHIEVED | | | | | |
|---|---|---|---|---|---|---|
| | Level 1 | | Level 2 | | Level 3 | |
| | *Signature* | *Date* | *Signature* | *Date* | *Signature* | *Date* |
| **Learning outcomes** | | | | | | |
| 1. Examine for presence of prolapse, compartments involved and stage of prolapse | | | | | | |
| 2. Record the clinical findings using POP-Q system or other prolapse methods | | | | | | |
| 3. Explain the clinical findings to the woman | | | | | | |
| 4. Relate the clinical findings to the symptoms (and if this is not possible, to consider alternative investigations or onward referral) | | | | | | |
| 5. Use the clinical findings to plan ongoing care or referral | | | | | | |

| 6. Seek clinical support where necessary | | | | | | |
|---|---|---|---|---|---|---|
| **Standard Achieved with Other Methodologies (please list below)** | | | | | | |
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| *Signature* | *Date* |
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| **Standard 5:**<br><br>**Assessment for fitting the first pessary** | **LEVEL OF COMPETENCE ACHIEVED** | | | | | |
|---|---|---|---|---|---|---|
| | **Level 1** | | **Level 2** | | **Level 3** | |
| | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** |
| **Learning outcomes** | | | | | | |
| 1. Explain clearly to the woman the process of assessment for the first pessary and how it differs from an examination for prolapse | | | | | | |
| 2. Explain that there will be an initial trial period for the pessary, and more than one fitting may be necessary to find the most suitable pessary | | | | | | |
| 3. Assess for vaginal atrophy and organise treatment accordingly | | | | | | |
| 4. Perform an assessment of vaginal dimensions and select a pessary type and size to suit the clinical findings | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 5. Insert the pessary | | | | | | |
| 6. Test for successful fit of the pessary | | | | | | |
| 7. Allow time to ambulate and pass urine after fitting | | | | | | |
| 8. Re-evaluate and reassess if the first pessary is not suitable or not retained | | | | | | |
| 9. Discuss pessary management advice e.g. sexual intercourse, support perineum when defecating, managing pessary dislodgement | | | | | | |
| 10. Ensure clear documentation of size and type of pessary that has been fitted | | | | | | |
| 11. Formulate a management plan for ongoing care and plan for safe change of the pessary in an appropriate environment e.g. self-management (if suitable), GP, or specialist clinic | | | | | | |

| 12. Seek clinical support where necessary | | | | | | |
|---|---|---|---|---|---|---|
| **Standard Achieved with Other Methodologies (please list below)** | | | | | | |
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| *Signature* | *Date* |
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| <u>Standard 6:</u><br><br>**Knowledge on alternatives to pessaries** | **LEVEL OF COMPETENCE ACHIEVED** | | | | | |
|---|---|---|---|---|---|---|
| | **Level 1** | | **Level 2** | | **Level 3** | |
| | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** | ***Signature*** | ***Date*** |
| **Learning outcomes** | | | | | | |
| 1. Explore what is important to a woman with regards to her treatment goals | | | | | | |
| 2. Discuss the option of "doing nothing" and the risks where relevant | | | | | | |
| 3. To offer a woman follow-up when she chooses to do nothing initially, and allow her to express any change in the management option chosen | | | | | | |
| 4. Discuss the option of pelvic floor muscle exercises and refer on if indicated | | | | | | |
| 5. Discuss the option of surgery to manage prolapse | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 6. Explain to a woman there are different types of surgery which may be offered to manage a prolapse, and this is dependent on the type of prolapse | | | | | | |
| 7. Explain to a woman that surgery carries risks, a failure rate and a risk of recurrence | | | | | | |

| **Standard Achieved with Other Methodologies (please list below)** | |
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| *Signature* | *Date* |

<table>
<tr><th rowspan="3"><u>Standard 7:</u><br><br>Pessary Self-Management</th><th colspan="6">LEVEL OF COMPETENCE ACHIEVED</th></tr>
<tr><th colspan="2">Level 1</th><th colspan="2">Level 2</th><th colspan="2">Level 3</th></tr>
<tr><th>Signature</th><th>Date</th><th>Signature</th><th>Date</th><th>Signature</th><th>Date</th></tr>
<tr><td colspan="7">Learning outcomes</td></tr>
<tr><td>1. Demonstrate indications and contraindications of pessary self-management</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2. Communicate effectively the benefits of pessary self-management to a woman and how self-management can be used to suit the woman’s lifestyle</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>3. Discuss the relevant anatomy, purpose of the pessary and location of the pessary once in situ</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>4. Teach a woman how to insert and remove a pessary, including being able to demonstrate folding and handling the pessary and discussing different positions</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

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|---|---|---|---|---|---|---|
| 5. Discuss pessary care (removal frequency, cleaning procedures, lubrication and storage) | | | | | | |
| 6. Advise on sexual intercourse | | | | | | |
| 7. Communicate effectively to a woman warning signs and when to contact her pessary clinician. | | | | | | |
| 8. Supply patient information to a woman to supplement pessary self-management care | | | | | | |

| **Standard Achieved with Other Methodologies (please list below)** |
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| *Signature* | *Date* |
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| | |

| **Standard 8:**<br><br>**Reflective Practice** | |
|---|---|
| **Record number and dates of each reflective practice here and seek supervisor sign-off accordingly.** | |
| *Signature* | *Date* |

<table>
<tr><th rowspan="3"><u>SELF-ASSESSMENT TABLE</u><br><br>Practitioners are invited to keep this self-assessment table updated for when they feel they have achieved each level of competence</th><th colspan="6">LEVEL OF COMPETENCE ACHIEVED</th></tr>
<tr><th colspan="2">Level 1</th><th colspan="2">Level 2</th><th colspan="2">Level 3</th></tr>
<tr><th>Signature</th><th>Date</th><th>Signature</th><th>Date</th><th>Signature</th><th>Date</th></tr>
<tr><td colspan="7">Learning outcomes</td></tr>
<tr><td>Standard 1: Removal and insertion of pessaries for routine changes</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Standard 2: Knowledge of the indications and management involved in pessary care</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Standard 3: Knowledge of how to manage complications of pessaries</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Standard 4: Prolapse assessment</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Standard 5: Assessment for fitting the first pessary</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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| Standard 6: Knowledge of alternatives to pessaries | | | | | | |
| Standard 7: Pessary self-management | | | | | | |
| Standard 8: Reflective Practice | | | | | | |

| ACTION PLANS FOR ONGOING PROGRESS<br><br>○ Supervisors and practitioners may use this space to highlight areas which can be worked on in order to progress through the levels<br>○ Each entry should have the date, the current level, the suggested action plan and a further date to review whether this has been achieved | |
|---|---|
| Standard 1: Removal and insertion of pessaries for routine changes | |
| Standard 2: Knowledge of the indications and management involved in pessary care | |
| Standard 3: Knowledge of how to manage complications of pessaries | |
| Standard 4: Prolapse assessment | |
| Standard 5: Assessment for fitting the first pessary | |
| Standard 6: Knowledge of alternatives to pessaries | |

| Standard 7: Pessary self-management | |
| --- | --- |
| Standard 8: Reflective Practice | |

## Additional Resources:

### NICE

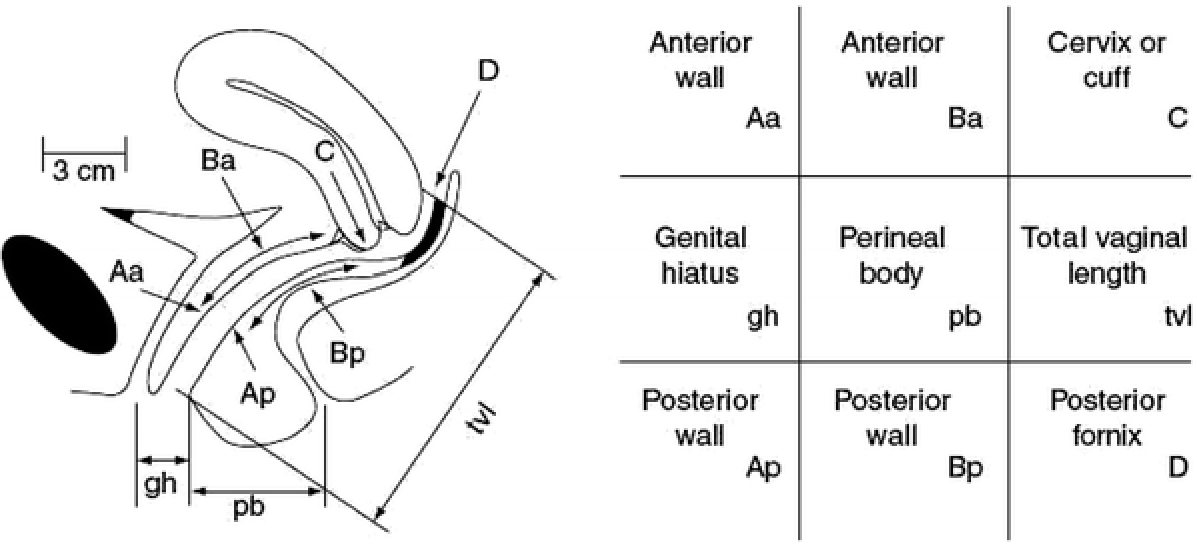
- Pathway for the management of pelvic organ prolapse

https://pathways.nice.org.uk/pathways/urinary-incontinence-and-pelvic-organ-prolapse-in-women

- Assessing Pelvic Organ Prolapse

https://www.nice.org.uk/guidance/ng123/chapter/Recommendations#assessing-pelvic-organ-prolapse

### Pelvic Organ Prolapse Quantification (POP-Q) System[31, 32]



## Appendix 5 – Pessary types

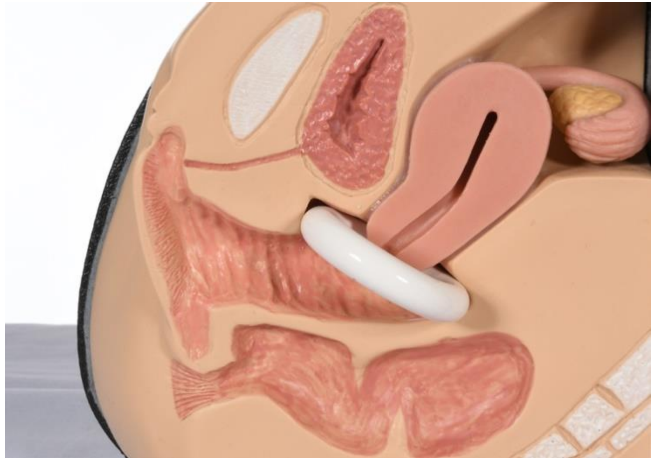
Pessary selection and sizing is often more of an art than a science. However, there are several factors that may be considered when selecting a pessary. These include the shape of the vagina, the severity of the pelvic organ prolapse, whether the patient would like to self-manage her pessary and if she wishes to commence or maintain sexual activity.

This section will describe each of the pessaries commonly used in the UK, discussing fitting and removal techniques along with information on materials and sizes for each type. Many pessaries are available in a variety of materials, some which are flexible and others that are rigid. Although, it is considered that some women may need a more rigid pessary to support their prolapse, many consider that a flexible pessary is more comfortable, easier to remove and insert and therefore easier to self-manage. A silicone pessary being softer may be less likely to erode the vaginal walls.

Women can be sexually active with some types of pessary in situ or they may choose to remove the pessary prior to intercourse. This may be more challenging with certain types of pessary for example the Gellhorn, shelf and Donut pessary.

It is noted that there are regional/local variations in pessary preferences and these may be due to experience, knowledge, availability and cost. Not all pessary clinicians will use all types of pessary in their routine practice, but an understanding of what is available and why it may be used is essential in managing cases where more conventional pessary types have been unsuccessful.

## Ring pessaries



## Overview

Rings are the most used pessaries. They can be fitted for any type of pelvic organ prolapse but may be less successful if the perineum is unable to provide enough support such that the ring is poorly retained or if the upper vagina is narrowed by previous surgery e.g. hysterectomy. Sexual activity is possible with the pessary in place as the vaginal space is not filled by the device although either partner may find sexual intercourse uncomfortable and may wish to remove it before sex. Self-management most commonly involves a ring pessary.

## Materials and sizes

PVC (vinyl) ring pessaries are latex free devices. The outer diameter can vary from 50–110 mm and are available in two materials; the flexible vinyl (PVC) pessary has a wall thickness of 12.5 mm and the rigid polythene pessary has a wall thickness of 7.5 mm. It is recommended by the group that the thicker (12.5 mm) ring pessary should be used in preference to the narrower more rigid (7.5 mm) pessary. These can be replaced as per the local policy or as indicated by the pessary condition.

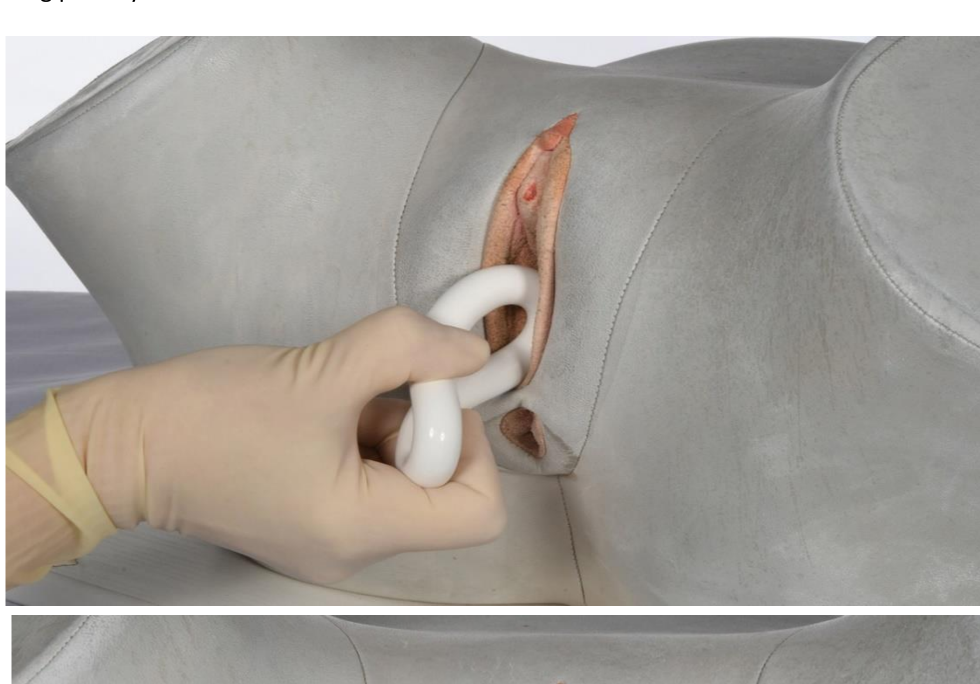
Silicone rings are also available; some of these contain a steel spring filling to help them keep their shape. These pessaries are more pliable than the PVC pessaries and as they can fold, are often easier to insert and remove so are useful for a woman who is self-managing. They are available in a variety of sizes from 44–127 mm outer diameter. Silicone pessaries are more expensive to buy but can be washed and re-inserted on many occasions. Different manufacturers recommended a variety of timescales but they range from 20 washes/reviews up to 10 years if the pessary is intact and not visibly damaged. Please refer to the individual manufacturer's recommendations for specific advice. Most silicone pessaries are powdered with a food-grade powder that must be washed off with water prior to insertion. Pessaries that contain a metal spring/core may need to be removed prior to certain investigations e.g. MRI scans.

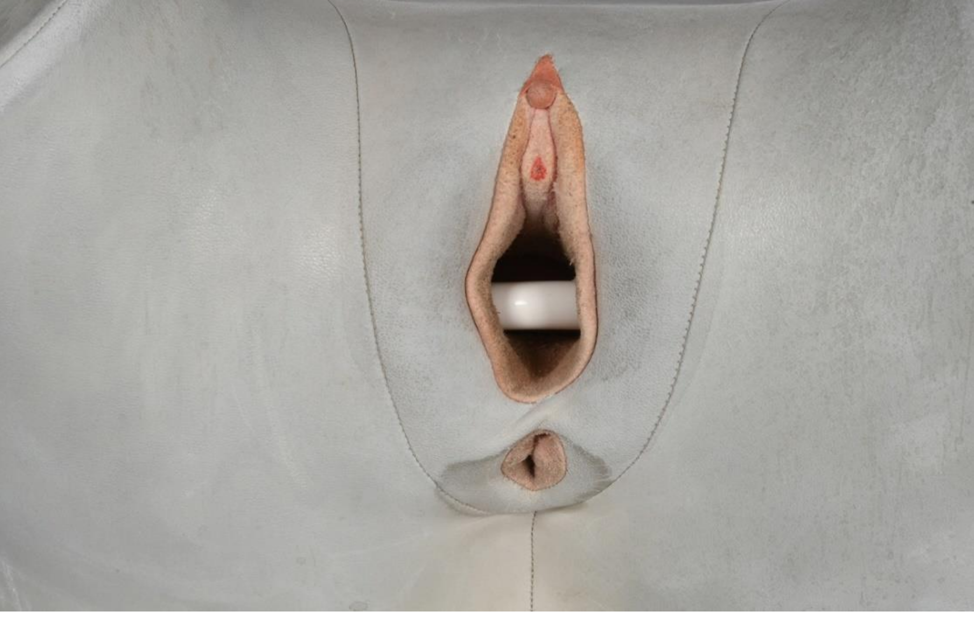
## Fitting

In order to fit a ring pessary, it should be compressed to reduce its width or twisted into a figure of eight. It may be helpful to run it under warm water to make it more pliable. The compression can be maintained by making a "tube" with the other hand for it to be gently pushed through during insertion as shown in the illustrations below. The compressed ring is introduced into the vagina

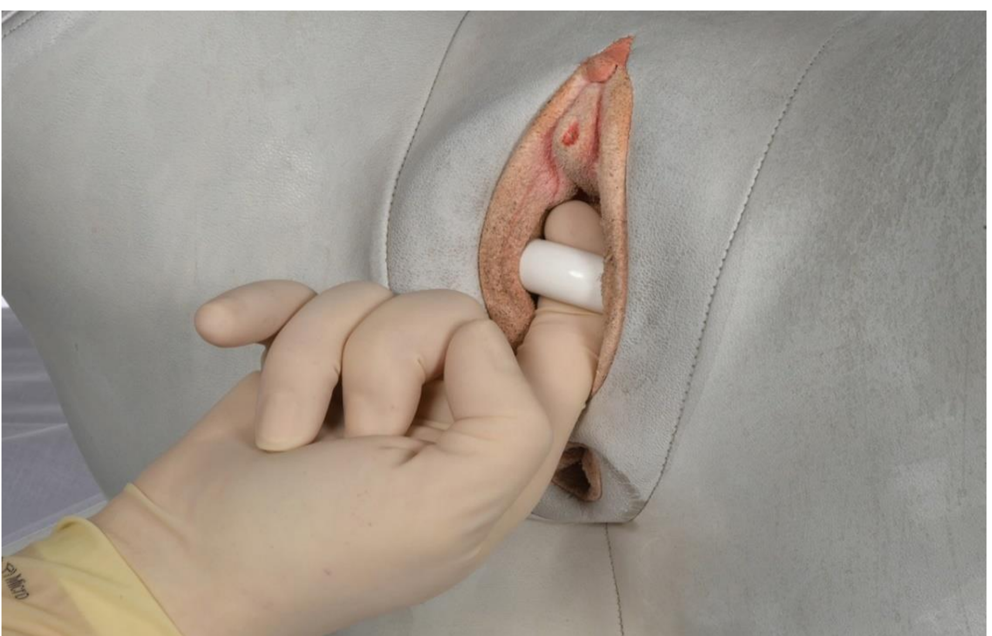
and once more than half of the compressed ring has been inserted, it can gradually be released as it is further inserted and will usually end up in the correct position without the need for much further adjustment. It may be pushed upwards with the index finger to locate the front edge behind the symphysis pubis. If a woman has a cervix, it should be ensured that the back edge of the pessary lies behind, and not in front, of the cervix. The correct position is with the posterior edge in the posterior vaginal fornix and the anterior edge behind the symphysis pubis. If the anterior edge sits directly under the symphysis pubis, the ring may be too large and may be uncomfortable or not retained. Once fitted a woman can be asked to cough and stand up to ensure the pessary remains in the correct position.

Ring pessary insertion





Ring pessary removal



## Removal

To remove a ring pessary, an index finger should be hooked around the anterior leading edge of the pessary to bring it down to the introitus. Once it reaches the introitus, it should be compressed as much as possible and then be very gently eased out of the vagina.

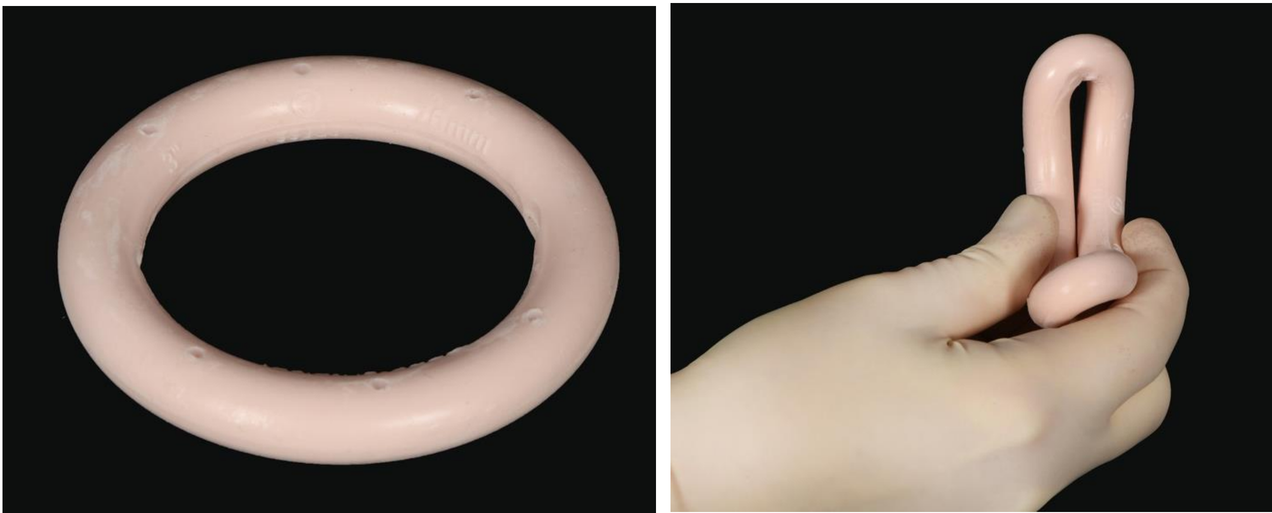
## Frequency of change/check

Traditionally, a woman seeing a health care professional (HCP) for routine changes of a ring pessary would be seen approximately every six months. For a woman who is self-managing, a review may take place yearly.

## Variations of ring pessaries

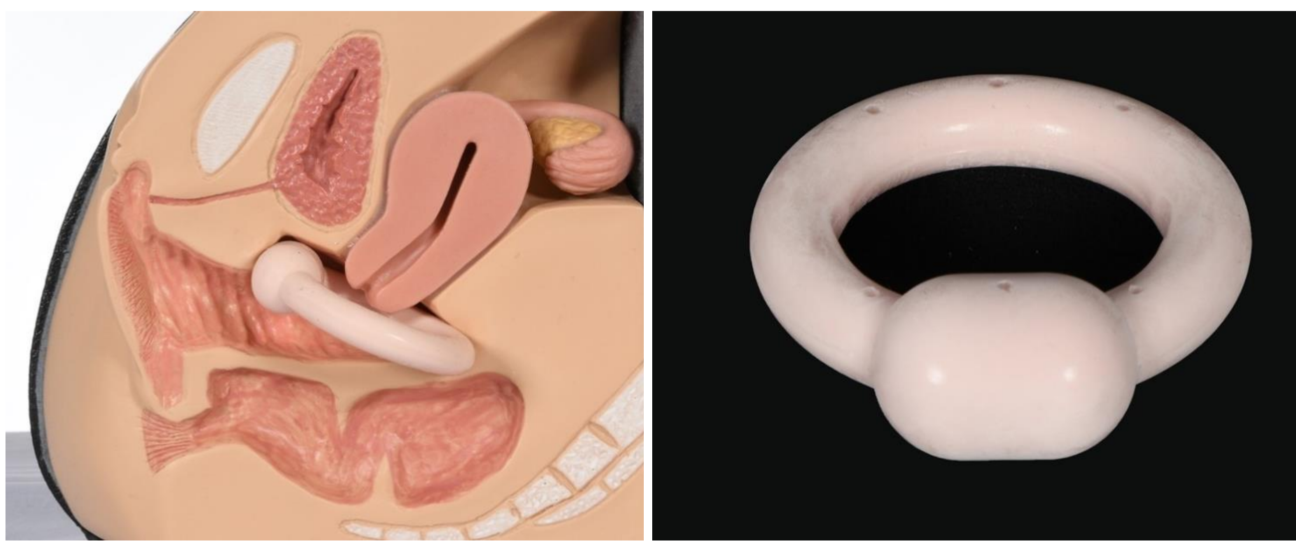
**Silicone folding ring pessary –** these are more pliable than vinyl pessaries and fold in the middle at the notches so are easier to insert and remove, especially in a woman with reduced manual dexterity. Insertion and removal techniques are similar to the vinyl ring but the pessary is folded rather than compressed or twisted. The pessary is inserted with the notches aligned to the front and back, then rotated once in place to position the notches to the sides to avoid the pessary folding and being expelled. It should be rotated back again before removing so that it folds correctly to aid removal.

Folding ring pessary



**Ring with knob** – is designed for a woman with both pelvic organ prolapse and stress urinary incontinence (SUI) and can also be useful when new symptoms of stress incontinence develop when her prolapse is reduced with an initial trial of a pessary without knob. The knob adds additional width to the pessary which may affect the sizing and provides support to the bladder neck to reduce SUI. It should be inserted like a standard ring but with the knob to one side and then rotated in the vagina so that the knob sits behind the symphysis pubis. It should be rotated back again before removal. For a woman without prolapse but just SUI, an incontinence pessary is available, which is the same design but with a thinner ring.

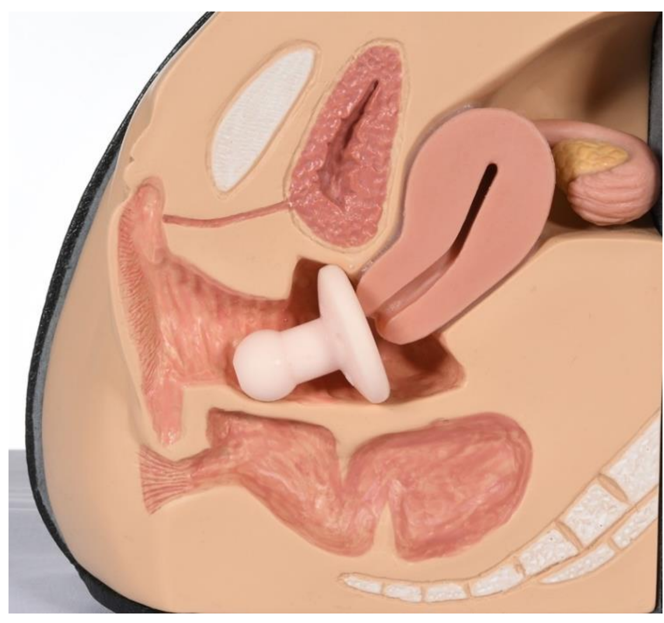
Ring pessary with knob



**Silicone ring with support –** for a woman who has a more significant degree of uterine prolapse, for example when the pessary is in place and she is aware of the prolapse protruding through the ring or feels that the pessary is not providing enough support, a ring with support may be considered. It provides a flexible supporting membrane with drainage ports that prevents the uterus falling though the centre of the ring.

Ring pessary with support

## Gellhorn pessary



## Overview

Gellhorn pessaries are a circular, flat plate with a stem in the centre which stabilizes the pessary in the vagina. It is often considered for a woman who has more advanced prolapse or who needs additional support. The cervix or vaginal vault rests behind the flat plate of the pessary and the stem should only be visible at the introitus when the woman performs a Valsalva manoeuvre (strains downwards). Although many women feel that sexual activity is not possible with a Gellhorn in, some women can maintain certain sexual activities. Self-management is a lot more difficult with this pessary but it is possible.

## Materials and Sizes

Most Gellhorn pessaries are made of a flexible silicone material, however rigid silicone and acrylic varieties are available. They are sized in two ways; the first in the same way as a ring pessary to determine the outer diameter size of the circular plate (available in 38–95 mm) and secondly the vaginal length must be considered to enable a choice between a standard-length stem or short stem. The pessary has drainage ports to allow the passage of fluids, although they do not readily allow drainage of menstrual flow.

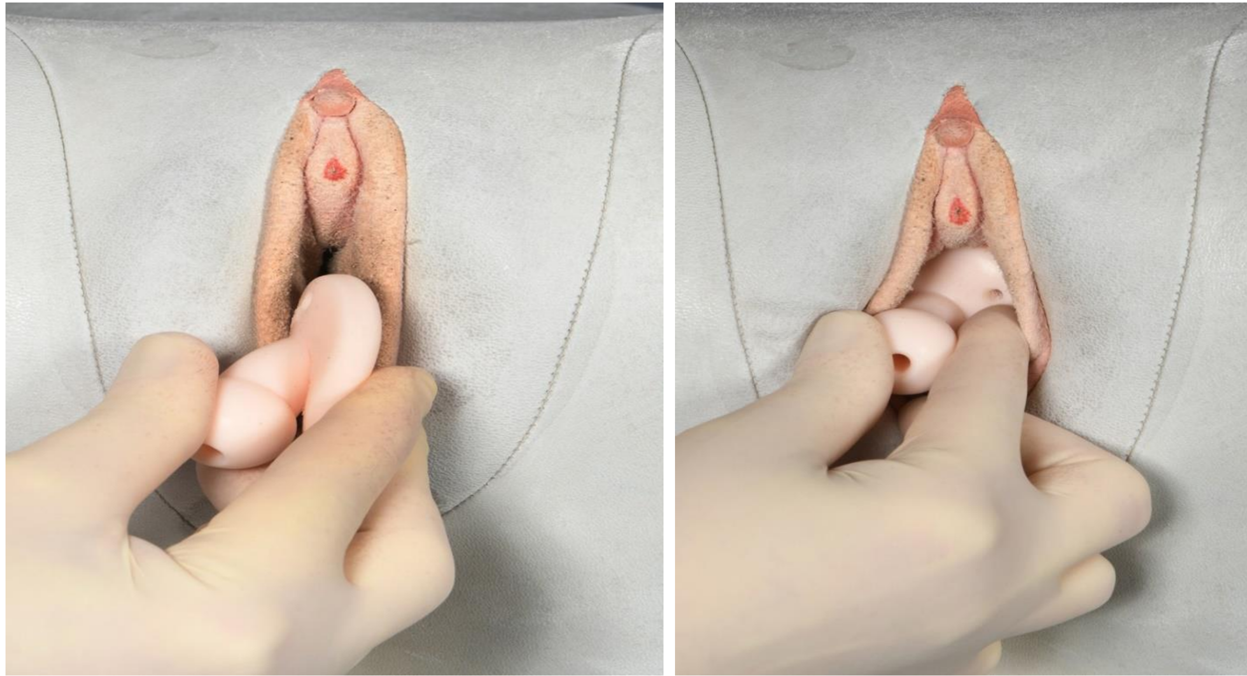
## Fitting

There are two options for Gellhorn pessary fitting depending on the estimated size of the Gellhorn and the size of the introitus:

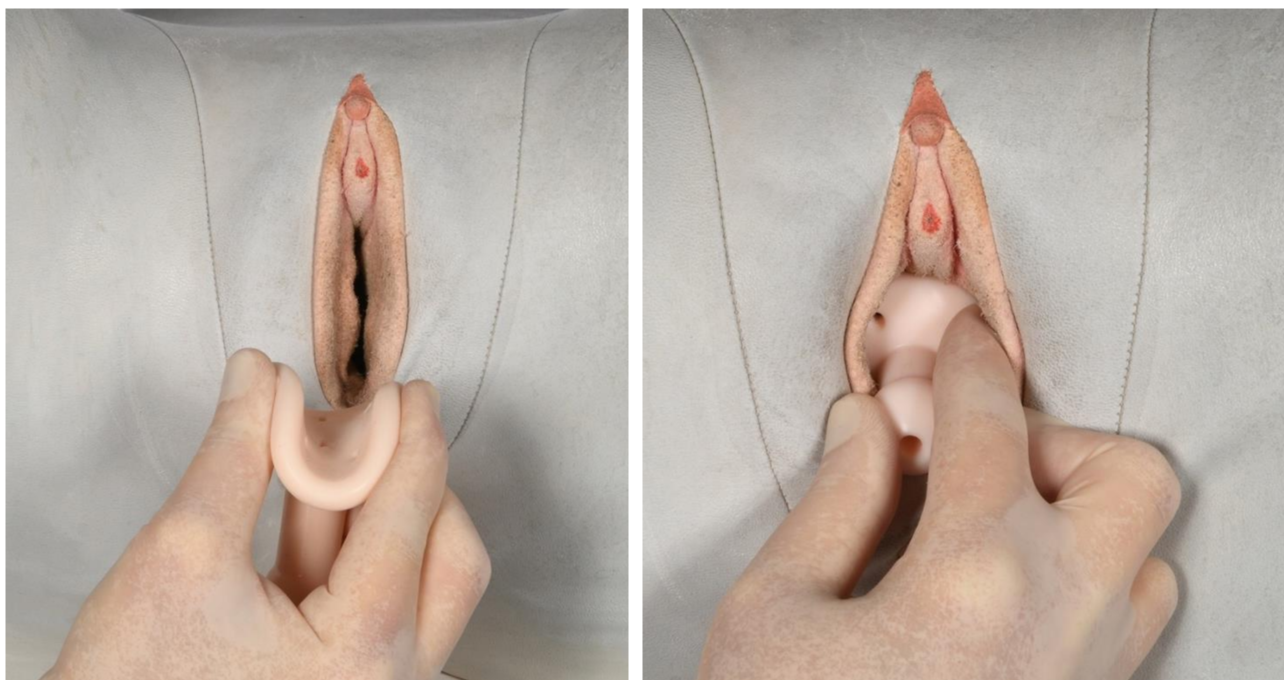
1. Holding it with the stem flattened sideways to compress the pessary, the edge of the plate is introduced first; once half of the plate is inside the vagina, the pessary is then rotated into a horizontal position whilst pushing it upwards at the same time so that the edge is placed in the posterior fornix with the stem sitting in the centre of the vagina.

2. Folding the plate of the pessary behind the stem, the pessary is then introduced into the vagina and pushed towards the posterior fornix, with the stem sitting in the centre of the vagina.

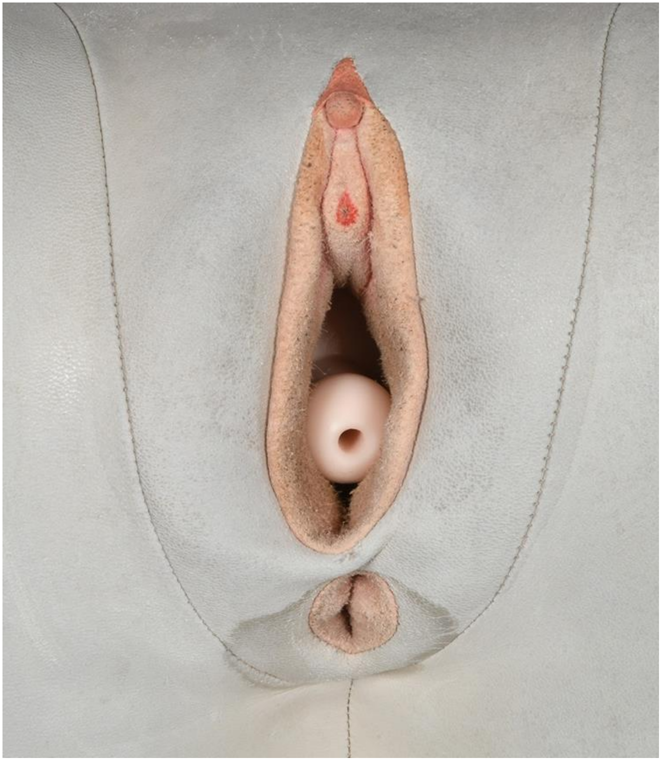
Gellhorn pessary insertion technique 1 stem folded



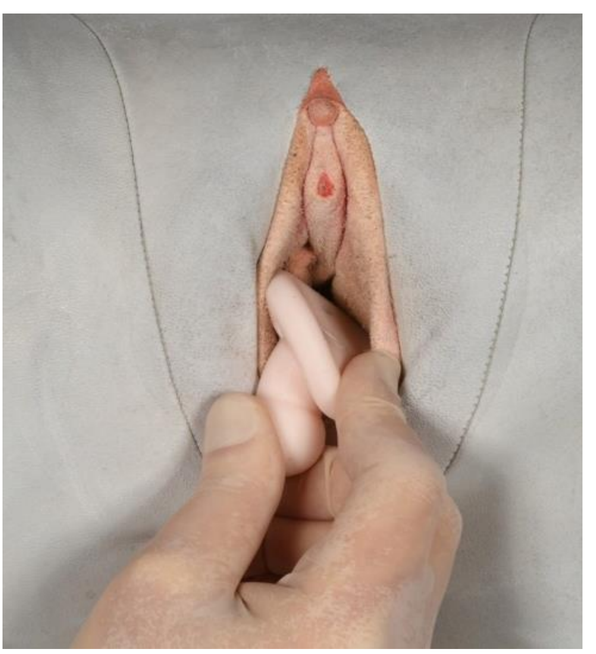
Gellhorn pessary insertion 2 plate folded



Gellhorn pessary in situ



Gellhorn pessary removal



## Removal

A finger needs to be introduced to the side of the plate to move it and release the suction. Once the plate is mobile, the pessary should be folded by placing the middle finger around the stem.

The index finger is then hooked round the edge of the plate folding it towards the stem whilst also bringing it down to the introitus. The tip of the stem needs to be outside the introitus before the plate can be gently eased out compressing the edges if possible, to reduce the diameter.

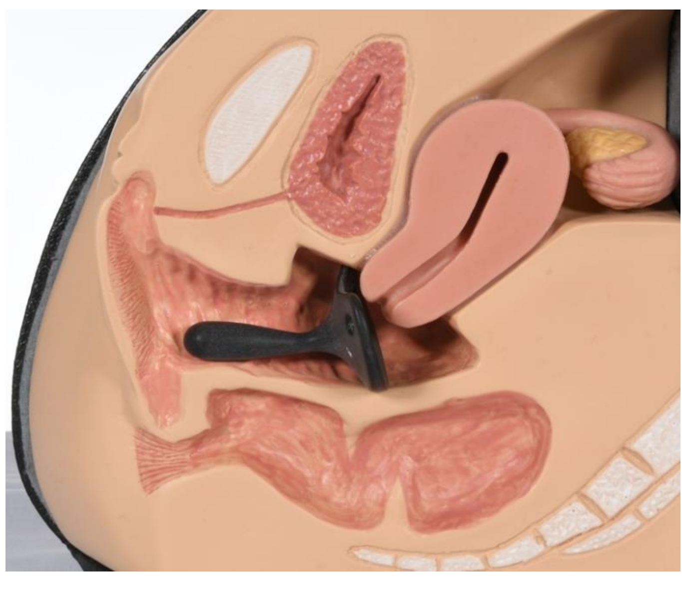
A Gellhorn pessary can be difficult to remove but the following may be tried:

- using a sponge holder on the stem to allow better grip and then easier access to slide your finger around the back to release the suction.
- a sponge holder can also be applied to the edge of the pessary to help bring it down.
- use of a speculum if the pessary is sitting high in the vagina can be helpful to find the stem to put the sponge holder onto to help remove it.
- water or a local anaesthetic gel can also be inserted through the stem of the pessary to help break the suction of the plate and facilitate removal without discomfort.
- asking the woman to lift her bottom slightly (bridging) or to roll onto her side can help release the suction and increase the space for easier removal

### Frequency of change/check

Most commonly, reviews take place every 3–6 months.

## Shelf pessary



## Overview

Shelf pessaries have a kidney-shaped plate for support with a curved stem in the centre for stabilization in the vagina. The convex edge of the pessary sits in the posterior vaginal fornix and the concave edge faces toward the bladder. It is usually used for a woman with more advanced prolapse. Challenges with sexual activities and self-management are the same as for the Gellhorn pessary.

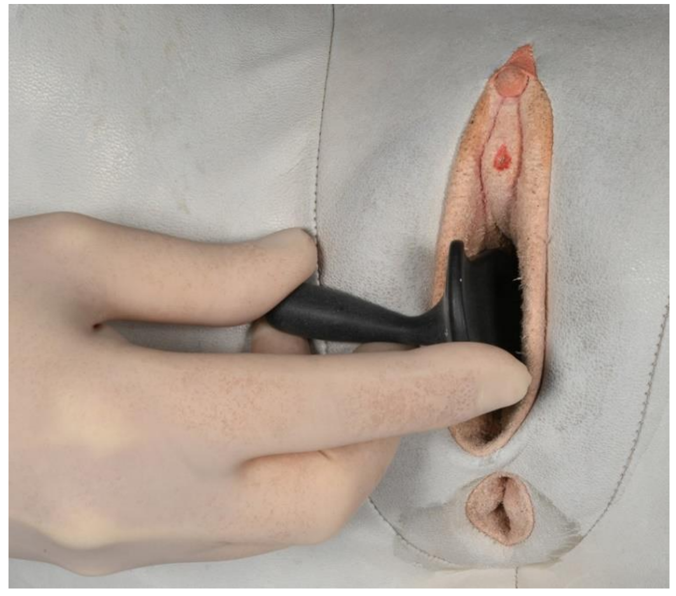
## Materials and Sizes

A shelf pessary may be rigid and not compressible (made of an acetyl copolymer) or made of silicone and compressible which makes removal easier. They are available in a range of different sizes (51–102 mm for the rigid and 38–95 mm for silicone). The silicone pessaries are also available in a standard and short stem length. The pessary has drainage ports to allow passage of fluids, although they do not readily allow drainage of menstrual flow.

## Fitting

It is fitted by holding it firmly with the stem pointing sideways so that the thin edge of the plate is introduced first. Once half of the plate is inside the vagina, the pessary is then rotated into a horizontal position whilst pushing it upwards at the same time so that the posterior round edge is placed in the posterior fornix. The stem should point forward.

Shelf pessary insertion



Shelf pessary removal

## Removal

The index finger is hooked behind the edge of the plate to release the suction that builds up between the pessary and the vaginal walls allowing the pessary to be brought down so that the tip of the stem is outside the vagina. Once the stem is outside, the pessary may be rotated to place the plate in a vertical position and ease it out of the introitus. Either the anterior or the posterior edge may be released first depending on which is easier.

## Frequency of change/check

Most commonly, reviews take place every 3–6 months**.**

## Shaatz pessary

### Overview

The Shaatz pessary is similar to the Gellhorn pessary but without a stem. It is recommended for a woman with a low or shallow pubic notch who cannot retain a ring pessary. It is ideal for a woman who wishes to maintain sexual activity but requires more support. It is suitable for self-management.

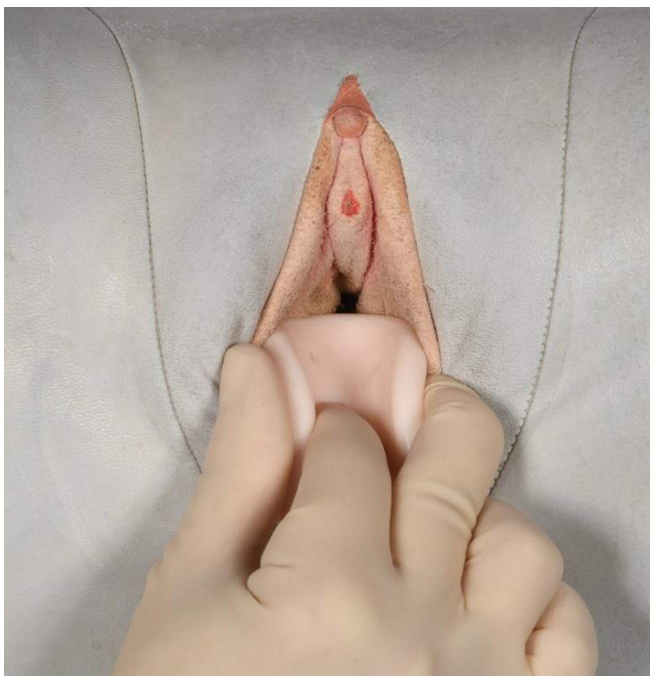
### Materials and Sizes

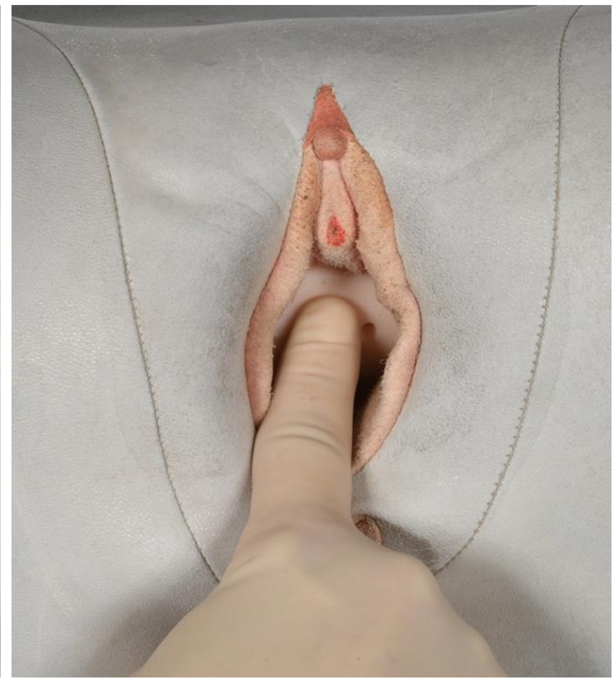
Shaatz pessaries are generally made of soft silicone and have drainage ports to allow the passage of fluids. Shaatz pessaries are also called folding Shaatz as they can fold in half making insertion and removal easier. They are available in a range of sizes between 38–95 mm outer diameters.

### Fitting

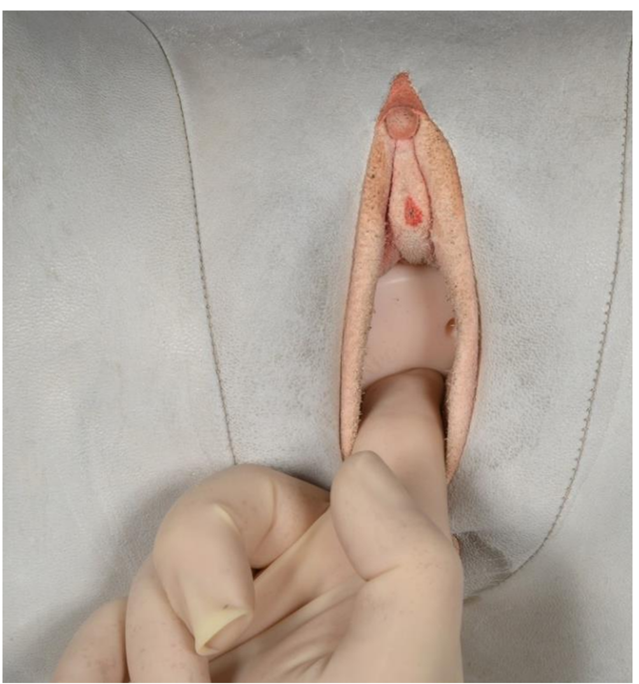
The Shaatz pessary is fitted in a similar way to a ring pessary. The concave side is towards the top of the vagina to allow mild suction.

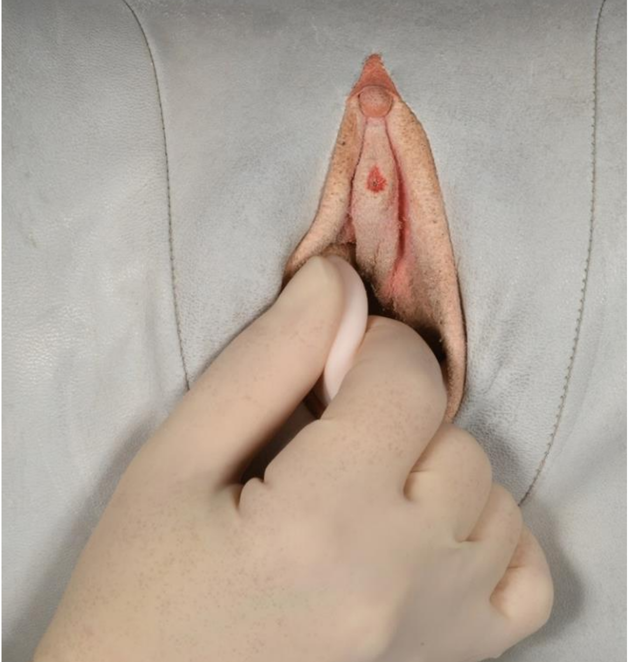
Shaatz pessary insertion





Shaatz pssary removal





## Removal

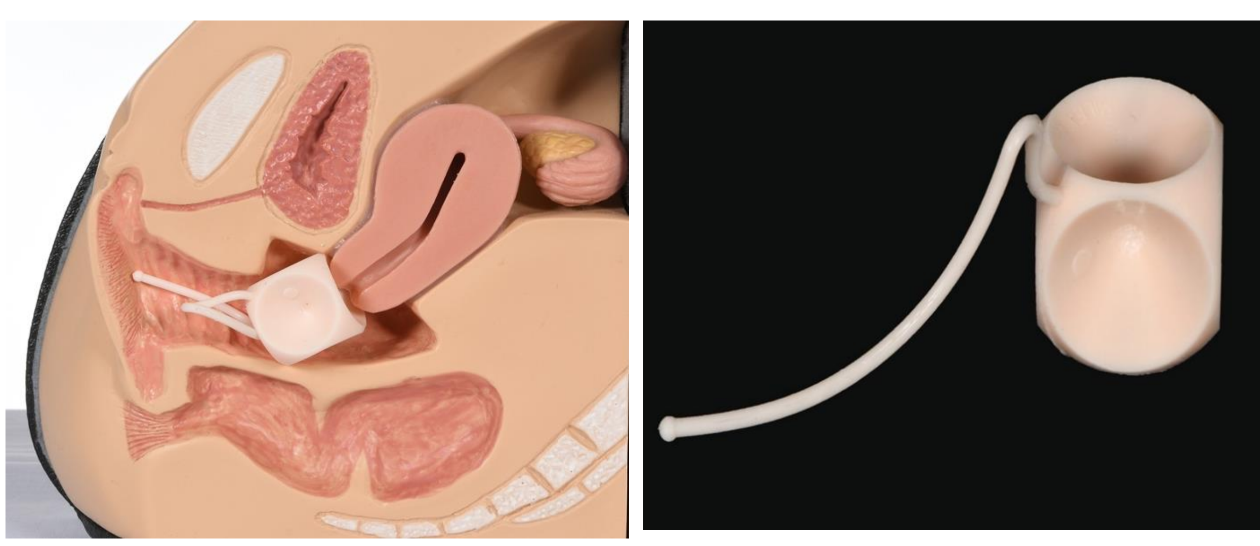
The pessary is removed by inserting one finger to the side of the plate to move it and release the suction and then into the large hole to bring the pessary down toward the introitus. The pessary is then turned so that the rim is almost parallel to the introitus. With one or two fingers of the other

hand, press down on the perineum and slide the pessary out. For removals that are difficult, try tying a long piece of dental floss through the ports of the pessary and use this to pull down to allow for an easier removal.

### Frequency of change/check

Most commonly, reviews take place every 3–6 months.

## Cube/Tandem cube



### Overview

The cube pessary has 6 concave sides that create a suction effect when in place in the vagina helping it to be retained. It is therefore often used in cases of more severe prolapse where other pessaries have failed. It is only suitable for a woman who can self-manage as it needs to be removed and cleaned daily. The woman will need a degree of manual dexterity to be able to manage insertion and removal. The pessary will need to be removed prior to sexual activity involving vaginal penetration.

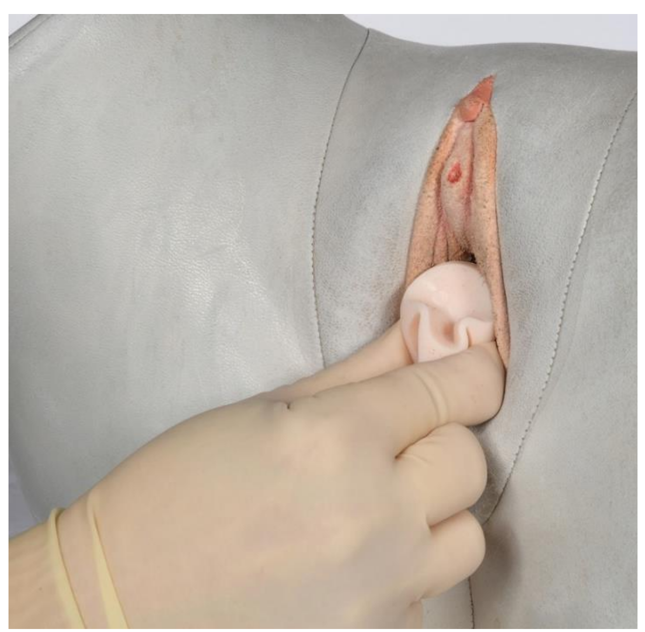
### Materials and Sizes

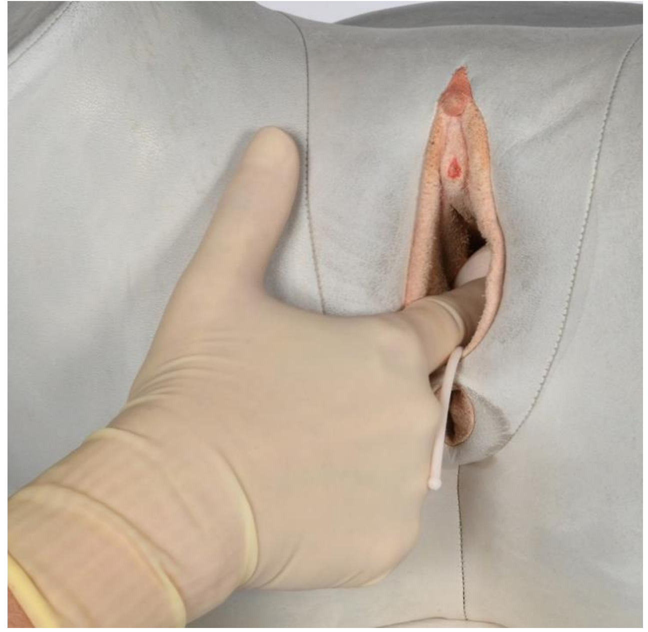
The cube is made of silicone and available in a variety of different sizes ranging from 25–75 mm and is also available with or without drainage holes. The pessary would be washed with mild soap and water each night. Some cubes have drainage ports to allow the passage of fluids. Although they do not readily allow passage of menstrual flow.

## Fitting

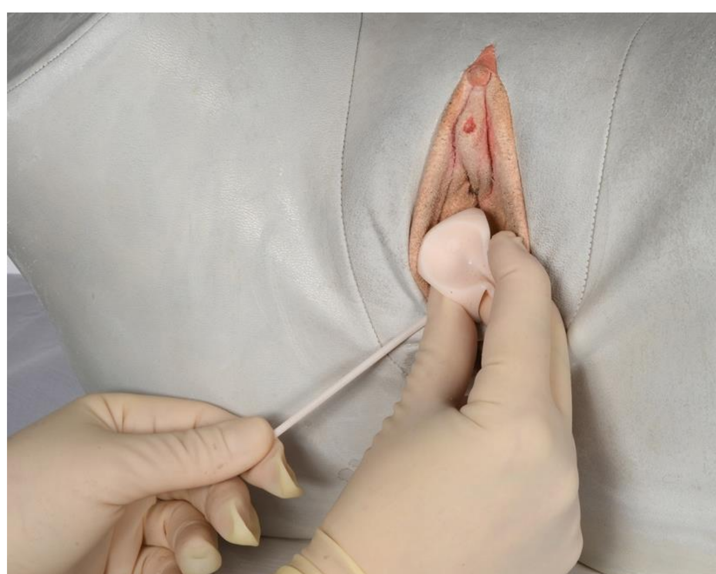
To insert it into the vagina, the cube should be pushed gently downwards into the vaginal space and then with downward pressure to the posterior vaginal wall whilst being turned gently to get past the vaginal entrance. Once inside the vagina, it should be pushed up as far as possible.

Cube pessary insertion





Cube pessary removal



## Removal

Daily removal is considered advisable.

The string of the pessary is used to help locate the base of the pessary. The string should not be used to pull the cube down and out.

A finger should be inserted into the vagina to sweep around the pessary and move it gently to break the suction. Gentle bearing down if required may help to get a firmer grasp of the pessary. Twisting the cube slightly to ease it out of the introitus may be helpful.

## Frequency of change/check

These need to be removed daily. Assessments by a HCP are routinely performed after the first 4–8 weeks of use and then at 3–6 monthly intervals thereafter to check the health of the vaginal walls.

## Variations of cube pessaries

**Tandem Cube**

This provides additional support for a woman who is unable to keep the largest size cube pessary in place. It has 10 concave sites increasing the overall suction of the pessary to increase adhesion to the vaginal walls.

## Donut

### Overview

The Donut pessary is designed to fill the vaginal space. The Donut is used for more severe stages of prolapse, especially those where the uterus is still present. Given its overall volume, it can be used to reduce bothersome posterior wall prolapses and can often be useful in reducing prolapse in a woman with a large genital hiatus. Because of the shape and size, these pessaries are more difficult to remove, especially in the case of self-management. Sexual activity is less likely with a Donut in place filling the vaginal space.

### Materials and Sizes

The Donut is made of flexible silicone. They are available in several sizes ranging from 51–95 mm.

### Fitting

The pessary should be compressed between the thumb and forefinger. A finger should be used to depress the perineum. Holding the Donut parallel to the introitus, the pessary should be inserted into the vaginal using a corkscrew motion and pushed up to the top of the vagina. The cervix/vaginal vault should rest behind the Donut.

### Removal

Hook one finger inside the centre of the pessary. Using the thumb and middle finger to compress the side of the Donut, angle the pessary and pull gently through the introitus using a finger on the other hand to press down on the perineum.

### Frequency of change/check

Most commonly, reviews take place every 3–6 months**.**

## Inflatable pessaries

### Overview

Like the Donut pessary, the inflatable pessary works by occupying the space in the vagina. The pessary consists of the head, which is inserted into the vagina, and the stem which sits outside of the body. The stem has a bead in the closed end which controls the inflation and deflation. A separate bulb (hand pump) is attached to the open end of the stem for inflation. An advantage of the inflatable design is that it is inflated once it is in situ, thus making insertion more comfortable for some women. However, this pessary needs to be removed and cleaned every night so a woman must be willing to self-manage. The pessary can be removed prior to sexual activity. The inflatable pessary should not be left in place for more than 24 consecutive hours.

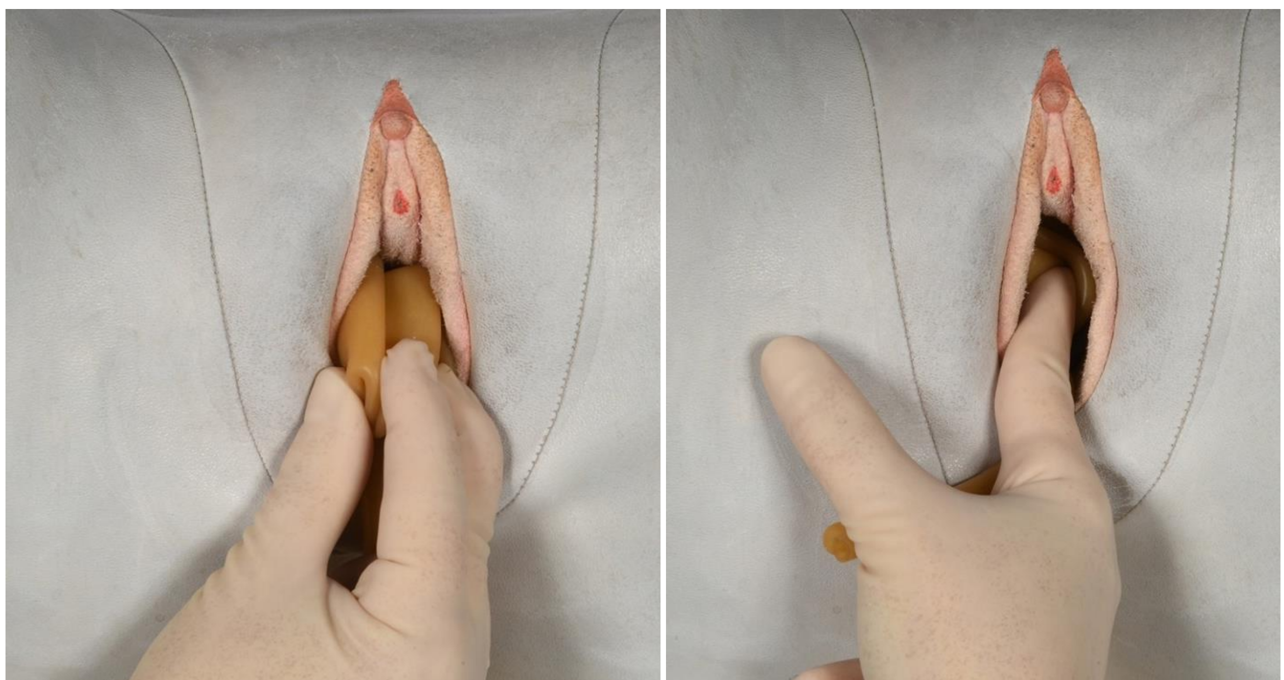
## Materials and Sizes

Inflatable pessaries are made of latex or silicone. They are available in four sizes ranging from 51–70 mm. The latex inflatable pessaries cannot be used in a woman with a latex allergy and should not be used with any vaginal hormone creams as these contain a wax base that will deteriorate the latex.

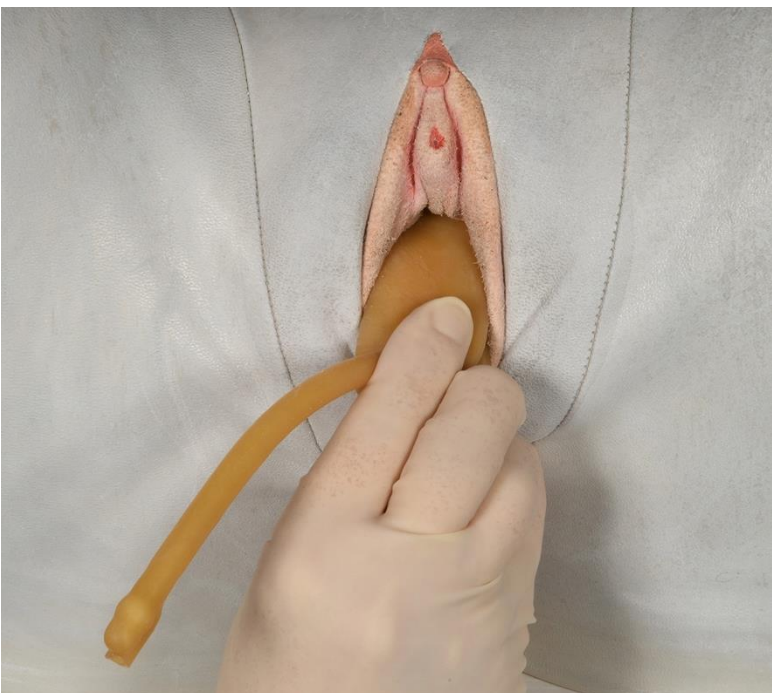
## Fitting

The pessary is deflated by moving the bead to the closed end of the stem. The bulb is then attached into the open end of the stem. The head of the pessary is then inserted into the vagina so that only the stem protrudes. The pessary is inflated by squeezing the bulb and the inflation level is controlled by the number of pumps. Once inflated the bead in the stem is moved forward to close the air vent and the bulb removed. The stem can either be tucked into the vagina or left outside.

Inflatable pessary insertion



Inflatable pessary removal



## Removal

The bead is moved into the closed end of the stem allowing the pessary to deflate. Using the stem as a guide the woman can grasp the deflated pessary and remove it. The stem should not be used to pull the pessary out.

## Frequency of change/check

A woman needs to remove and wash the pessary with warm soapy water daily. HCP's will usually review after the first 4–8 weeks of use and every 6–12 months thereafter.

# Vaginal Dish pessaries with knob/ urethral bowl

## Overview

Dish pessaries are a circular vaginal pessary, with a cupped shallow bowl (with or without support) with a knob that is designed to lift the bladder neck. This elevation can reduce symptoms of stress urinary incontinence but as it can sit nicely behind the pubic bone it can also work effectively in supporting a large anterior prolapse with or without uterine descent where a ring has failed, whether there is incontinence or not. This can be useful, when a woman does not want a more complex pessary such as a Gellhorn, particularly if she wants to remain sexually active. Self-management is possible with this pessary.

## Materials and Sizes

Pessaries are made of a soft flexible silicone material. They are sized in a similar way to a standard ring pessary but the knob will add to the general diameter (55–90 mm) so a smaller diameter may be needed against normal measurement. There is, however, some manufacturer variation of roundness of the knob and careful consideration needs to be given to some that have a squarer knob that provide less support.

The pessary with support has drainage ports to allow the passage of fluids. Although they do not readily allow passage of menstrual flow.

### Fitting

The pessary is fitted by holding the two edges of the diameter with the knob at the top to compress the pessary. The opposite edge of the knob is inserted first towards the posterior fornix pushing the knob up behind the pubic bone.

### Removal

The pessary is removed by inserting one finger into the large hole under the knob to bring the pessary down toward the introitus. Alternatively, put a finger over the top of the knob first and then remove. The pessary is gently then pulled down and the edges will generally collapse as it is removed.

### Frequency of change/check

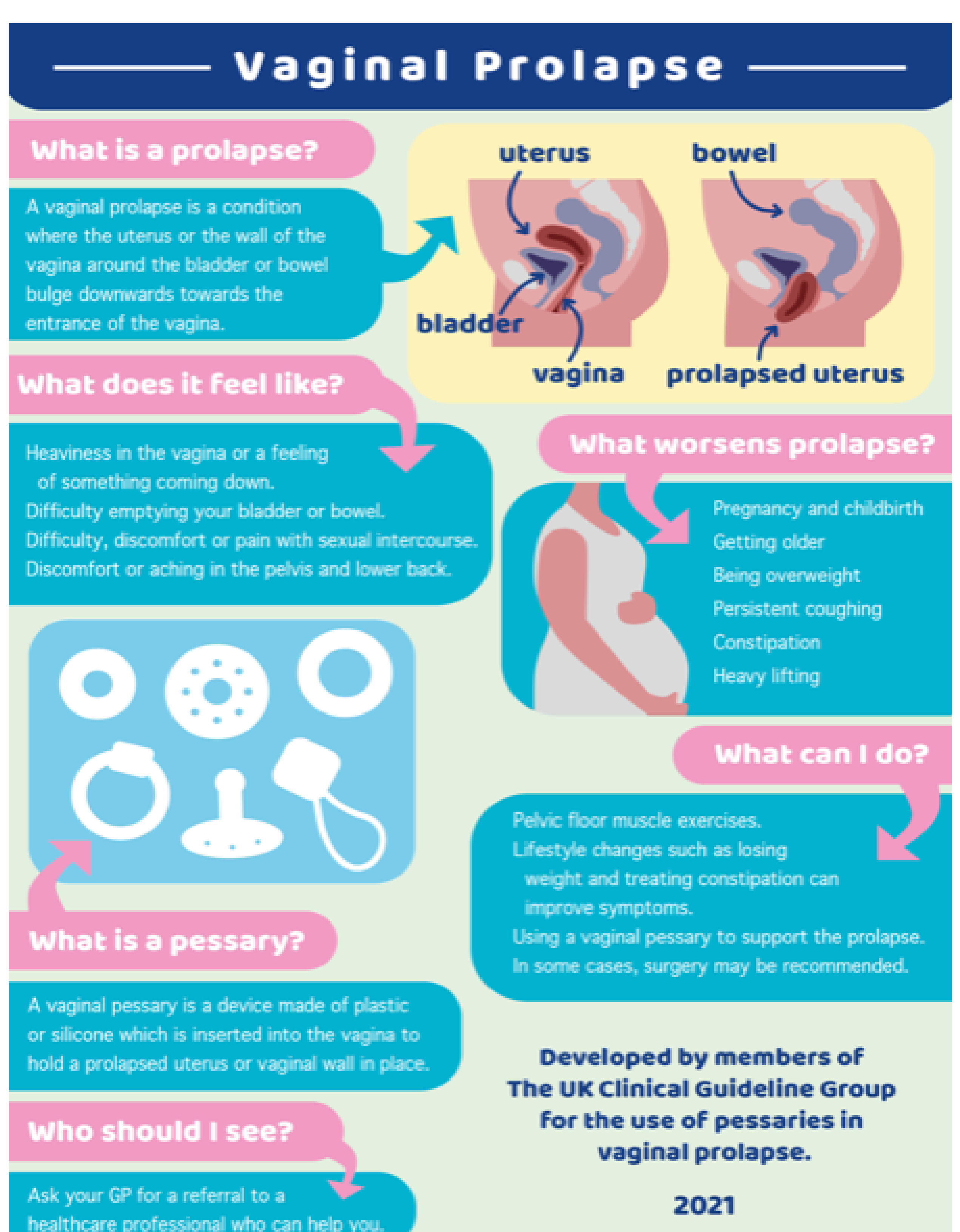
Most commonly, reviews take place every 3–6 months. If self-managing, this can be less frequent.

### Other Pessaries

There are several other types of pessary available in the UK that have not been included in this section as they are very rarely used. These include (but are not limited to) the Gehrung, Hodge, Smith, Risser, Marland and Regula pessaries. Specific information related to these products can be found in the manufacturer’s instructions.

## Appendix 6 – Patient information

Infographic: Vaginal Prolapse



## Information for Women using a pessary for vaginal prolapse

## Using a pessary for vaginal prolapse

This leaflet explains what vaginal prolapse is, the benefits and the risks of having a pessary for treatment of vaginal prolapse, and the alternatives to pessaries.

We have answered the most common questions asked by women regarding prolapse and pessaries. However, we do understand that every woman's situation is different and individual to them and advice from an appropriate healthcare professional is always preferable. If you do have any specific questions, it is important to speak to your own doctor, nurse specialist or physiotherapist for further help.

## What is a vaginal prolapse?

Vaginal prolapse is a common condition where the walls of the vagina and sometimes the uterus (womb), or vaginal roof (if you have had a hysterectomy) bulge downwards towards the entrance of the vagina. A vaginal prolapse is also known as a pelvic organ prolapse.

**Fig.1 Female external anatomy – No prolapse visible at vaginal entrance**

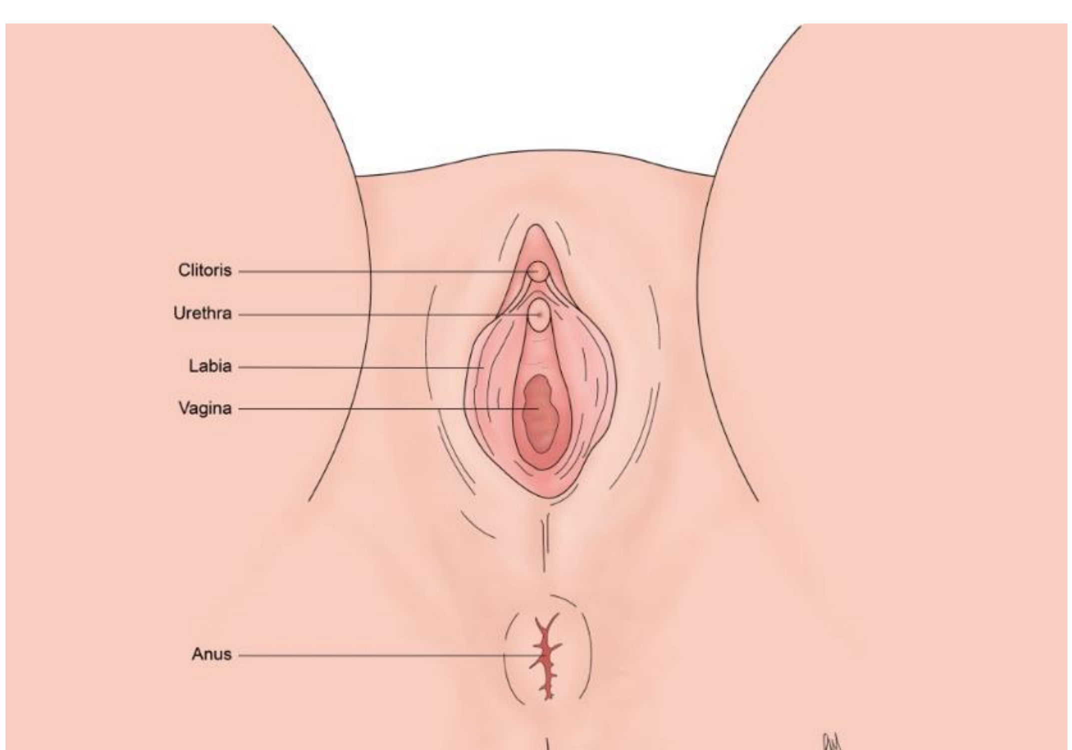
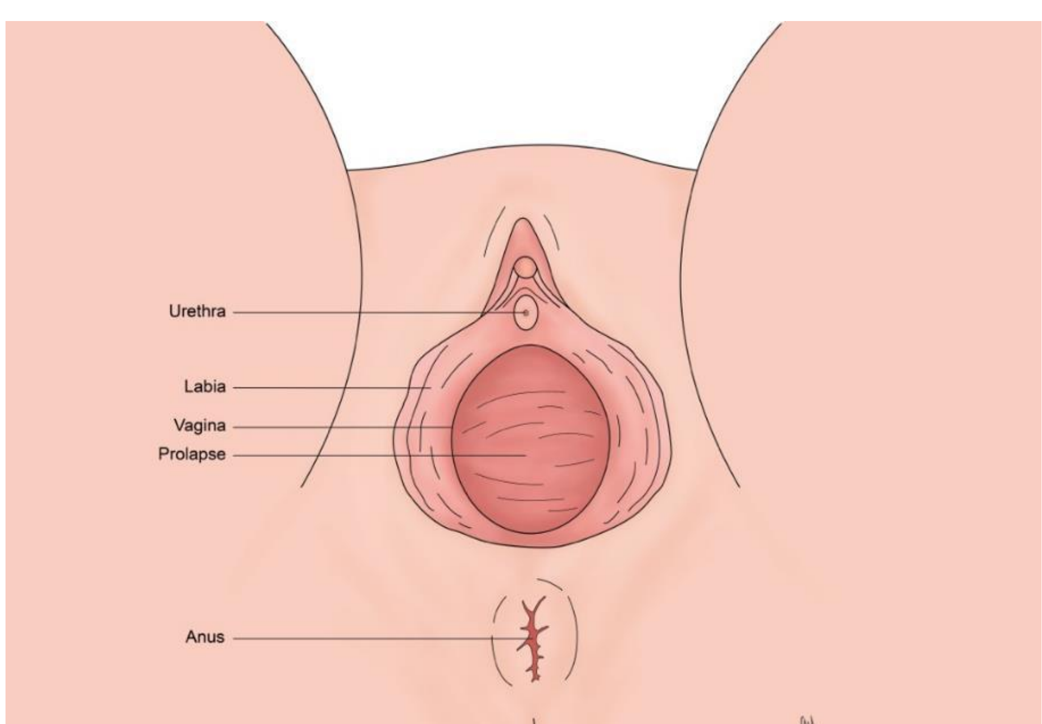


**Fig.2 Female external anatomy – Prolapse visible at vaginal entrance**




*UK Clinical Guideline Group for the use of pessaries in vaginal prolapse © POGP2021*

## What are the symptoms of a vaginal prolapse?

You could have one or more of these symptoms:

- A feeling of something coming down, a dragging sensation or a bulge in the vagina
- Difficulty emptying your bladder or bowel
- Discomfort/pain during sexual intercourse
- Discomfort or aching in the pelvis and low backache

### What increases the risk of vaginal prolapse?

Some women have connective tissue in the body that is more flexible and provides less support than others, so can be more likely to prolapse. This can be aggravated by other factors such as:-

- Pregnancy and childbirth
- Getting older
- Being overweight
- Persistent coughing
- Constipation
- Heavy lifting

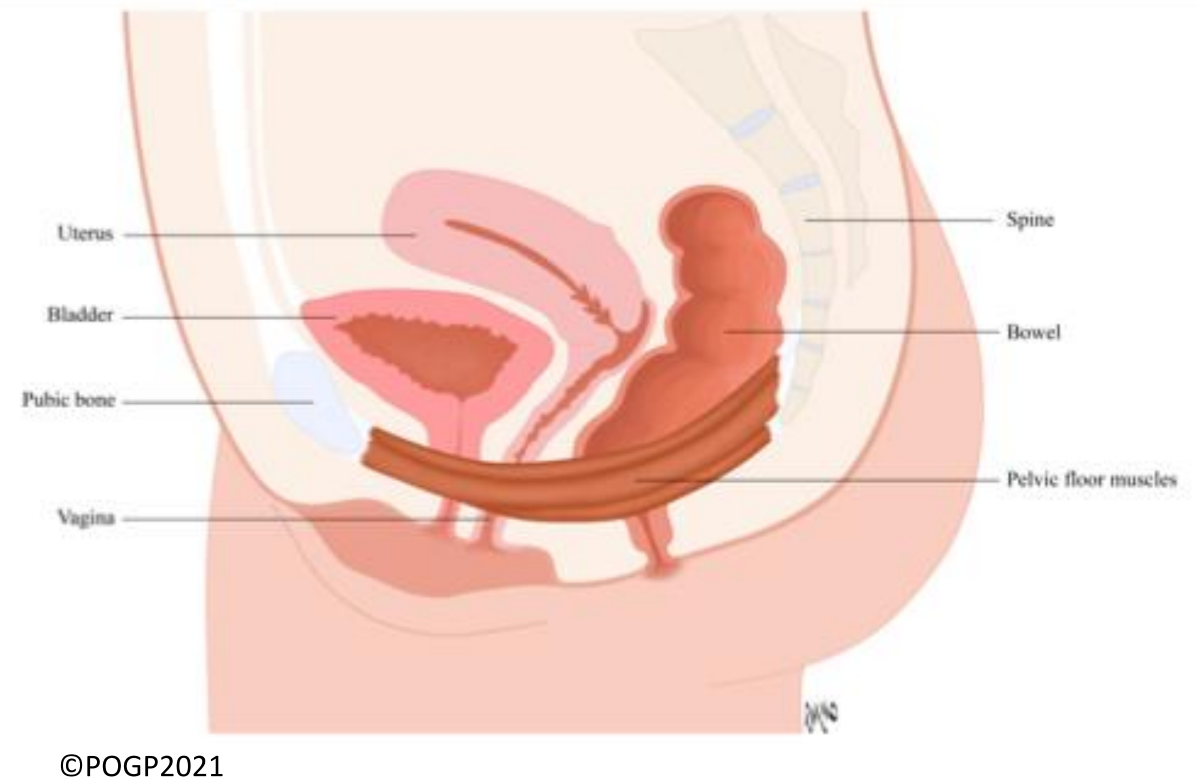
### What can be done to help improve your symptoms?

**The following are sometimes referred to as 'conservative' or 'non-surgical' approaches.**

- Lifestyle changes can reduce symptoms.Losing weight, treating constipation and reducing heavy lifting all reduce the pressure on your pelvic floor muscles. Pelvic floor muscles are shown in the picture below (figure 3). They help to support your pelvic organs – bladder, bowel and uterus.
- Using a vaginal pessary to support the prolapse alongside doing pelvic floor exercises.
- Pelvic floor muscle exercises help to strengthen the muscles and will help improve support
    - Information about pelvic floor muscle exercises: https://thepogp.co.uk/patients/pelvic_health_advice/pelvic_floor_muscles.aspx
    - Audio pelvic floor muscle exercise guide: https://www.youtube.com/watch?v=92KUPKi-ii4&feature=emb_logo

    If you have difficulty doing the exercises, are worried that you might not be getting them right or find that your symptoms are not reducing, you can ask to be referred to a pelvic health physiotherapist.

**Fig.3 Female pelvic floor muscles**

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**In some cases, surgery may be recommended. Surgery is offered when other non-surgical options haven't managed to control or reduce your symptoms.**

It is recommended that you see a pelvic health physiotherapist before considering surgery for a small or medium sized prolapse.

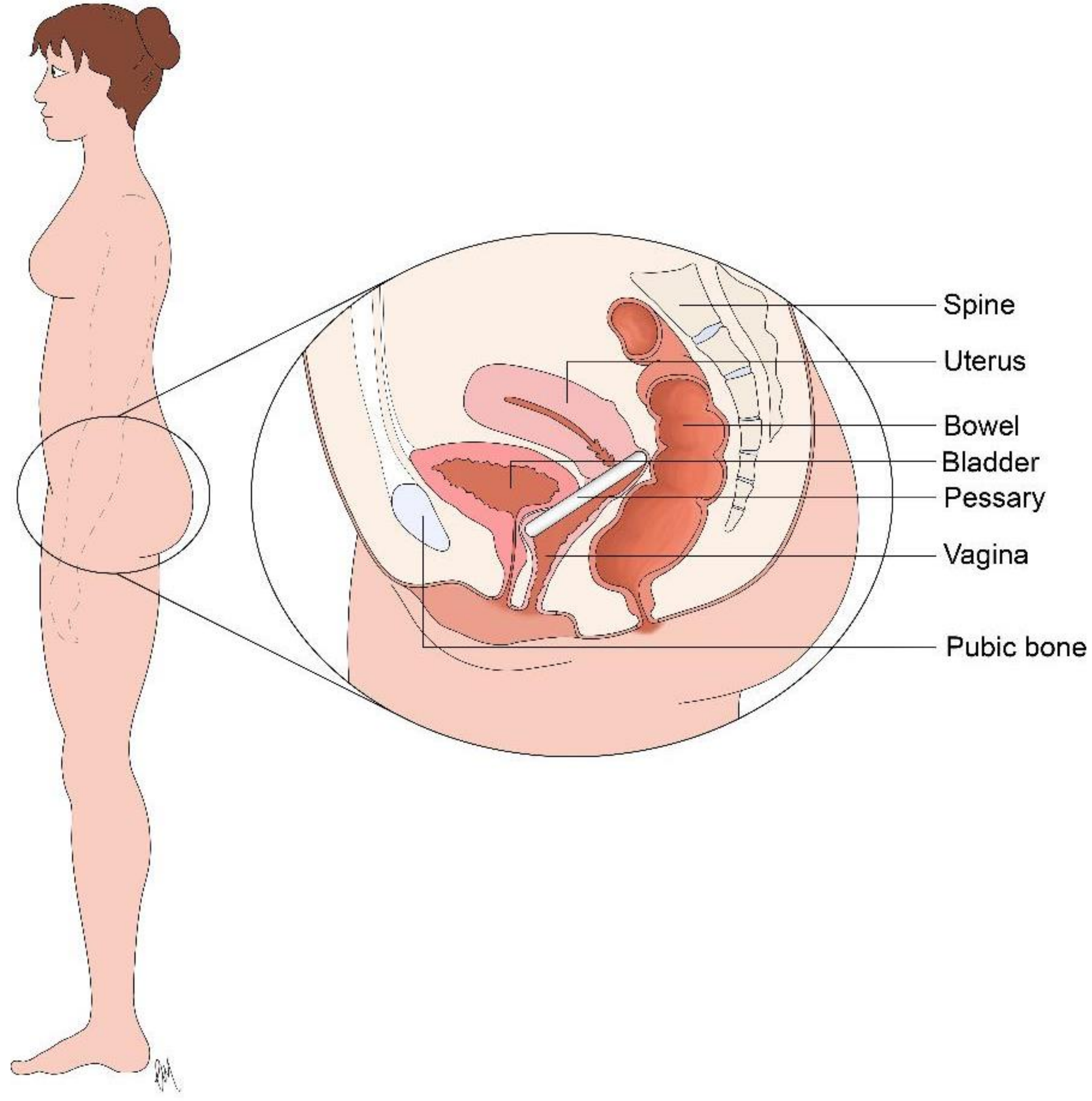
## What is a vaginal pessary?

A vaginal pessary is a device, made of plastic or silicone, which is inserted into the vagina to hold a prolapsed uterus or vaginal wall in place. It will also support your bowel and bladder. There are different types of pessaries and the healthcare professional who assesses your prolapse will discuss the type best suited to you. It sometimes takes more than one visit to get the right size, fit and type for you.

## What are the benefits of a vaginal pessary?

Once fitted correctly a vaginal pessary may help to reduce your symptoms and make you feel more comfortable. You will be able to continue with your everyday activities including exercising, working and caring for your family.

**Fig.4 Inside view of female anatomy – with pessary sitting in place in the vagina**




*UK Clinical Guideline Group for the use of pessaries in vaginal prolapse © POGP2021*

**PLEASE NOTE:** This diagram is an illustration of how the pessary supports the vaginal walls and is not "the correct position". The exact position that the pessary rests in will be very personal to you and may be much lower.

## What are the risks of a vaginal pessary?

There are a few side effects and risks. Your healthcare professional will tell you about these.

- You may notice you have more vaginal discharge than normal. If the discharge is offensive see your pessary fitting clinician or your GP.
- Occasionally bladder or bowel function could be affected.
- You may have vaginal irritation. If you feel sore, and have been through the menopause, you may benefit from using vaginal oestrogen.
- Long-term use of a vaginal pessary may cause ulcers (sores) inside the vagina, and/or infection. To reduce the risk of this happening, your pessary should be changed every 4–6 months. You may also be prescribed vaginal oestrogen.

**Vaginal oestrogen** can be used either as a cream or in the form of a pellet or a ring (also called a pessary) which is inserted into the vagina. The hormone is absorbed by the vaginal tissue and works locally. This means that unlike other hormone replacement therapy (HRT) the amount absorbed into the blood stream and travelling round the body (systemic absorption) is very small. Your healthcare professional will advise you as to which oestrogen is most suitable for you.

## Self -Management of Vaginal Pessary

Infographic: self-management of vaginal pessary

## Information for Women on Self-Management of Pessary for Vaginal Prolapse – leaflet

### To self-manage your pessary, you need to:

- Want to self-manage
- Have the ability and confidence to remove and reinsert the pessary
- Be aware of how to look after the pessary e.g. checking its condition and cleaning the pessary
- Be able to re-order a new pessary or request one on repeat prescription
- Monitor any changes and recognise when help or advice might be needed

### Removing and reinserting the pessary

- The person who assessed you and fitted your pessary will have shown you how to put the pessary in and take it out. Help will be available until you feel confident to do this on your own.
- You will be advised how often to remove the pessary depending on the type of pessary you are given.
- For pessaries that don't need to be removed daily there are no hard and fast rules on how long you keep a pessary inserted, but as a minimum it is recommended that you remove it every three months.
- There is no harm in removing your pessary and leaving it out for a period of time if you wish to. For example: you could remove it overnight then wash and reinsert in the morning about once a month.
- You could just use it for exercise if that is the only time your prolapse bothers you.
- You can discuss any questions you have about removing your pessary with the person who provided you with the pessary.

### Cleaning the pessary

You will be advised how to clean your pessary. It usually involves washing with warm water and a mild pure soap. There is no need to sterilise the pessary. Sterilising can have an adverse effect on the material that the pessary is made from. When cleaning your pessary, it is a good idea to check its condition. Look for any cracks or splits in the material that might have appeared or a general change in the pessary's condition. Discolouration of the pessary often occurs and is not harmful.

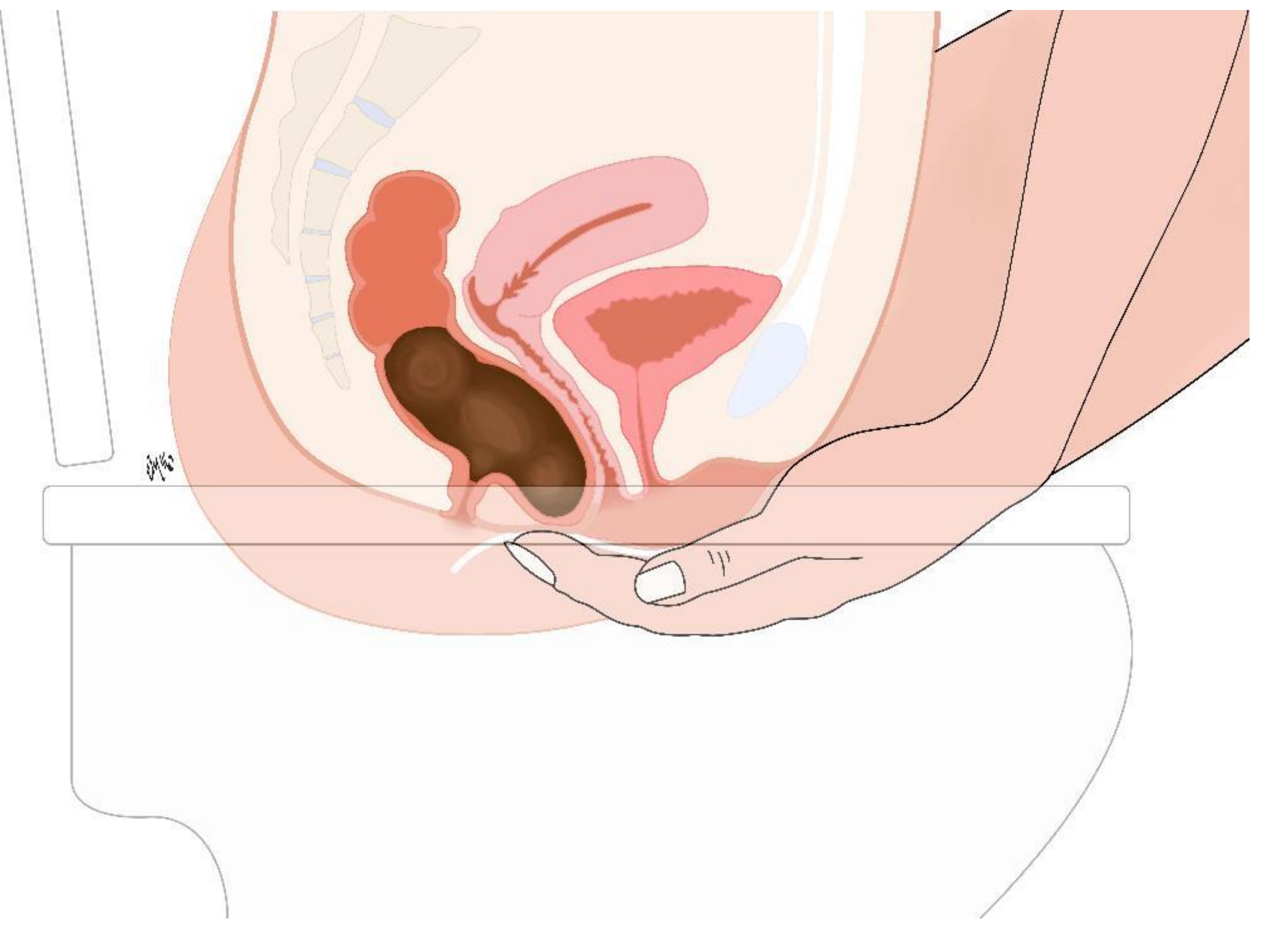
## Changing the pessary

You will be told at the clinic where your pessary was fitted, whether you should either order a new replacement pessary from the clinic directly or request it on repeat prescription. As a guide the minimum time for changing and replacing the pessary with a new one is once every 6 months.

## Tips to help with any changes to your condition

- If you have difficulty emptying your bladder or bowel remove the pessary first and once you have successfully passed urine or opened your bowels wash the pessary and reinsert it. If this happens regularly contact your clinician as you might benefit from a smaller size pessary.
- Avoid getting constipated
- Supporting the area between the anus and the opening of the vagina (figure 5)) when opening your bowels gives confidence to push without pushing the pessary out. Wrap toilet paper or a sanitary pad around your hand and press and support the area just in front of the anus and around the opening of the vagina.

Figure 5: Hand support when opening bowels



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- Occasionally a pessary may come out completely and you may need to wash and reinsert it or replace with a new one. If this happens often contact your clinician as you might need a bigger size of pessary.

- It is normal for the pessary to move sometimes. This may cause discomfort. If this happens, try moving the pessary back into position.

- It is a good idea to have a spare pessary available.

**If any of the following symptoms occur, you should contact the clinic or your GP**

- **Smelly or offensive discharge**. An increase in discharge is very common but it should not be smelly. If you notice smelly discharge, contact your clinic or GP. You can change pessaries more often to help with discharge.

- **Bleeding from the vagina**. If this happens, take the pessary out if you are able to and contact your clinic or GP.

- **Soreness, discomfort or pain**. If this happens, take the pessary out if you are able to and contact your clinic or GP.

## Frequently Asked Questions

### Who will fit my pessary?

A qualified health care professional with experience in managing pessaries.

### Can I ask for a female practitioner?

Yes, you can, although there may not be a female practitioner available in every clinic so you may want to make this request in advance of your appointment. You should be offered a chaperone and you may also choose to have someone else with you such as a partner or friend.

### Will I get a choice of device, or see what my pessary looks like before it is fitted?

Not all pessaries work for all women and all types of prolapse. After you have been assessed, the person who is fitting your pessary should show you which device is most likely to be appropriate for you. They will discuss your options with you, which may include the option of managing the pessary yourself. They will then show you the device, explain how it works and fit your pessary with your consent.

N.B. Sometimes it can take more than one fitting to find the device and size that works best for you. Throughout the process your doctor, nurse practitioner, or physiotherapist will work with you to make sure that you get the best possible results.

### How do you know what size to fit? What does it look like?

The person fitting your pessary will have assessed which size pessary is required and will show the pessary to you before it is fitted. Ask to see what it looks like.

### What is it made of?

Pessaries are usually made of plastic or silicone.

### Will I feel it in place?

No, ideally you should not feel it once it is in place and have a good fit. However, the pessary can move within the vagina, a bit like a tampon, so you may be aware of it at times, but it should not be uncomfortable. The person fitting your pessary will be able to show you what to do If it does become uncomfortable.

### Will it fall out when I exercise?

A pessary should not fall out if correctly fitted. There is an element of trial and error when fitting pessaries for the first time, so a pessary could fall out while you are trying different ones. Once you have a well-fitting and comfortable pessary, it will not come out during exercise, but it can still move.

### Should I give up my exercise activities?

No. You should be able to continue exercise with a pessary. Many women find they can be more active once they have a correctly fitted device in place.

### I have been doing pelvic floor exercises. Should I continue with them?

Yes. It is important to continue with your pelvic floor exercises.

### Can I use a tampon?

Yes. You can use a tampon if you have a ring type pessary as long as it feels comfortable.

### Will it fall out when I strain to open my bowels?

Supporting the area between the anus and the vagina when opening your bowels gives confidence to push, without pushing the pessary out. Wrap toilet paper or a sanitary pad around your hand and press and support the area just in front of the anus and around the opening of the vagina. Avoid getting constipated.

### How often should a pessary be checked or changed?

Depending on which type of pessary you have, this can be every 3–6 months by a healthcare professional. For self-managing pessaries, how often you remove a pessary depends on the type of pessary you were given and personal choice, but it is still important to check your pessary regularly. For pessaries that don’t require removing daily, they can be removed occasionally, for example once a week or a month, though you do not have to do this if you don't want to. As a guide the minimal time for changing a pessary and replacing it with a new one is once every 6 months.

## Will I be prone to more vaginal infections?

You may occasionally get a vaginal infection which can be treated with a local antibiotic vaginal cream or by removing the pessary and leaving it out for a while. Oral antibiotic tablets will be given if required.

An infection is less likely if the pessary is changed regularly and the vaginal tissues are kept healthy by using vaginal oestrogen which may be prescribed.

## Will it affect my sex life?

It is possible to have penetrative vaginal sex with some pessaries such as a ring or Shaatz pessary, but others would have to be removed first and replaced later. You will be able to discuss with your healthcare professional options of which pessary might best suit you, along with any concerns you may also have about contraception.

## How difficult is it to remove and put back in?

Some pessaries can be self-managed. The clinician who fitted your device will assess suitability and discuss this with you and will teach you how to remove it and reinsert it while you are with them in clinic. It is not usually difficult to remove a pessary or replace one once you have been shown how and have practiced.

## Can I self-manage my pessary?

Yes. You may be offered self-management of your pessary by your healthcare professional if suitable. You can manage your pessary yourself once you have been shown how to, have practiced and are confident to do so.

## Do I need to use lubricants?

You may find it more comfortable to use a vaginal lubricant when inserting a pessary, especially a new one, but you do not have to.

## What is vaginal oestrogen and why might I need it?

Vaginal or topical oestrogen is a very low dose of the hormone oestrogen.

Vaginal oestrogen can be used either as a cream or in the form of a pellet (also called a pessary) which is inserted into the vagina and absorbed by the vaginal tissue. This is also available as a ring-shaped device which releases hormone slowly over 3 months. This means that unlike other hormone replacement therapy (HRT) the amount absorbed into the blood stream and therefore traveling round the body (systemic absorption) is very small.

Oestrogen is found naturally in the body and one of its functions is to keep the condition of the vaginal tissues healthy. Oestrogen can be lacking during and after the menopause and it can cause vaginal atrophy. Vaginal atrophy is when the lining of the vagina becomes thin and dry and the skin around or in the vagina can feel sore or itchy. Your healthcare professional will advise you if you need oestrogen and which type will be most suitable for you

## How effective will vaginal oestrogen be?

Oestrogen cream can be very effective at making the condition of the vagina healthier and reducing soreness and discomfort and in turn, reducing the risks of infection and ulcers which a vaginal pessary may cause.

## Can I expect my prolapse condition to go back to normal after a while or is this it for the rest of my life?

No. Using a vaginal pessary controls the symptoms of a prolapse by supporting it. The pessary will not 'heal' or 'cure' the prolapse. Sometimes when the pessary is removed, there may be a temporary improvement, but this is not likely to last over time.

## Is this currently the preferred treatment for prolapse?

It is one of a small number of choices available for managing vaginal prolapse, but each woman is different and treatment choice varies with each individual. You can change your mind about your treatment at any time.

## My friend had surgery and that was fine for her. This was not offered to me as an option. What are my options?

Surgery may be considered but often women are offered a less invasive option to try first as all surgery will carry some risk including prolapse recurrence. Surgery for prolapse may include hysterectomy if the uterus has prolapsed. However, with some surgical procedures women do not need to have a hysterectomy. Removing the uterus itself does not always cure the prolapse and may make other types of prolapses more common.

## Can I buy a pessary from my local chemist myself to experiment myself?

It is possible to buy online but it is not advisable without having been assessed by a trained professional who can make sure you have the correct and most suitable pessary. There are a large variety of pessaries on the market and an appropriately trained healthcare professional will be able to help you find one that is likely to help you and your specific prolapse and symptoms. If you buy one online, it would be advisable to ask a healthcare professional to check it is suitable for you before you use it.

## What happens if I am self-managing my pessary and it gets stuck?

Don't panic! It is much easier to remove a pessary if you are relaxed and in the right frame of mind.

Contact the clinic where the pessary was fitted, your GP or go to the nearest A&E.

**Useful Contact details**

**Your Clinic is:**

**Contact Telephone number:**

**Your pessary is:**

## Useful Reading

- The Pelvic Obstetric and Gynaecological Physiotherapy website
  https://thepogp.co.uk

- Vaginal Prolapse
  https://thepogp.co.uk/patient_information/womens_health/vaginal_prolapse.aspx

- Pelvic organ prolapse: a physiotherapy guide for women
  https://thepogp.co.uk/_userfiles/pages/files/POGP-Prolapse_2.pdf

- Pelvic floor muscle exercises for women
  https://thepogp.co.uk/_userfiles/pages/files/POGP-PelvicFloor%20(UL).pdf

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