Clinical Pathway for Pessary Use for Prolapse

Woman presents with symptomatic prolapse

Complete a focused history, clinical examination and investigations to exclude other causes and follow pathways for concomitant symptoms such as incontinence and constipation. See: [Recommendations | Pelvic floor dysfunction: prevention and non-surgical management | Guidance | NICE]

Reassurance if clinically indicated and not bothersome

Assess type and quantify pelvic organ prolapse

Assess suitability for vaginal pessary

- preference for conservative management
- intact cognition
- willingness to attend regular follow up
- willingness to self-manage
- adequate physical mobility and dexterity
- sexually active
- good vaginal and vulval health

Consider vaginal oestrogen treatment prior to pessary management in women with evidence of vaginal atrophy

Assess contraindications

- severe genital atrophy or narrowing
- unexplained vaginal bleeding and/or discharge
- current vaginal or cervical cancer
- non-biological vaginal mesh erosion
- pelvic inflammatory disease (PID)
- inability to comply with face-to-face follow up

RISKS AND COMPLICATIONS

Common complications

- mild vaginal discharge
- constipation
- vaginal bleeding
- mild erosion
- denovo or increase in existing urinary incontinence

Severe/Less common complications

- severe vaginal discharge associated with infection e.g. bacterial vaginosis
- voiding difficulties, retention and/or urinary tract infection
- impacted/embedded pessary +/- fistulae
- cervical incarceration
- septicaemia
- vaginal or cervical cancer

Prior to pessary fitting

- explanation of how different types of pessary work including opportunity to see and touch
- explanation of benefits, risks and complications; advantages of self-management and need for regular attendance review
- obtain informed consent

Pessary selection

- dependent on whether woman wants to self-manage and is sexually active or not
- otherwise, no set rules on type of pessary offered, and can often be trial and error
- dependent partly on clinician's experience and availability of pessaries

refer to pessary choice algorithm

Sizing of pessary

A combination of 2 measurements on vaginal examination

- **length**-measure from the posterior fornix to the pubic symphysis
- **width** - spread the index and the middle fingers horizontally at the level of the cervix or vaginal vault
- visually compare with selected pessary

Fitting of pessary

- rinse any residue from the new pessary with water
- apply water-based gel to leading edge of pessary
- separate the labia, asking woman to relax her pelvic floor muscles
- insert pessary and position behind the pubic arch
- allow space for a finger breadth around the pessary

Refer to manufacturer's instructions and local policies **if re-fitting** - use a new pessary when cleaning is not appropriate

Assessment of fitting

- check there is no pain or discomfort once in situ
- ensure pessary is retained in supine on coughing and valsalva
- ensure pessary is retained on standing on coughing, valsalva and on usual movement
- ensure woman can void
- assess any immediate effect on occult UI

FOR SELF-MANAGEMENT

- teach & assess competency of self-removal and re-insertion which can be done daily, weekly or need to be left out overnight (cube)
- initial review - can be virtual in a few weeks or patient initiated and then face-to-face annually if woman happy and no complications

- document type and size of pessary for both woman and medical notes
- give patient information leaflet (PIL)
- give contact details
- arrange face-to-face follow-up (minimum 6 mths)
- instruct patient to seek advice if any complications or problems

Face-to-face/Virtual follow up & review

- symptomatic review and wish to continue
- assess for any complications
- review pessary fitting prior to removal
- remove pessary
- inspect vaginal health
- if no problems, replace pessary as per initial fitting

REFER TO REVIEW CHECKLIST

ASSESS FOR POTENTIAL COMPLICATIONS

Assessment of complications

POTENTIAL COMPLICATIONS AND MANAGEMENT

Mild vaginal discharge

- reassurance
- exclude and treat any underlying cause such as thrush

Malodorous vaginal discharge

- consider removal of pessary
- exclude any underlying cause such as infection and treat as appropriate following local and notional guidelines

Vaginal bleeding due to abrasion /erosion /ulceration

- removal of pessary is usually recommended and will need to be discussed with the woman until the vagina heals (re-assess 2-4 weeks)
- vaginal oestrogen can aid vaginal skin healing
- if the underlying cause is a tight pessary and replace with a smaller pessary once healed
- vaginal biopsy should be considered when ulcerations do not heal

Unexplained vaginal bleeding

- follow normal TWR (2 week rule) or suspected cancer pathways

Pain or discomfort, urinary incontinence/voiding difficulties/ constipation whilst pessary in situ

- remove pessary, consider re-sizing/ different type

Difficult removal due to granulation of neglected pessary

- insert local oestrogen cream and leave in situ for 20-30mins before trying gently to insert a finger behind the pessary and rotating the pessary before re-attempting removal. Alternatively send home with oestrogen cream for vaginal application nightly and try again in 2 weeks

Embedded pessary

- consider specialist referral for removal
- if removal is not viable in clinic, then consider removal under anaesthetic in theatre

Other complications or repeated complications

- pessary removal and seek specialist advice/treatment including alternative POP support (e.g. vaginal packing) if pessary not able to be replaced

Ongoing care

- document symptoms, complications and any treatment
- complete audit data as per local protocol
- record ongoing pessary type and size
- provide information to woman and provide PIL as required
- arrange next follow-up