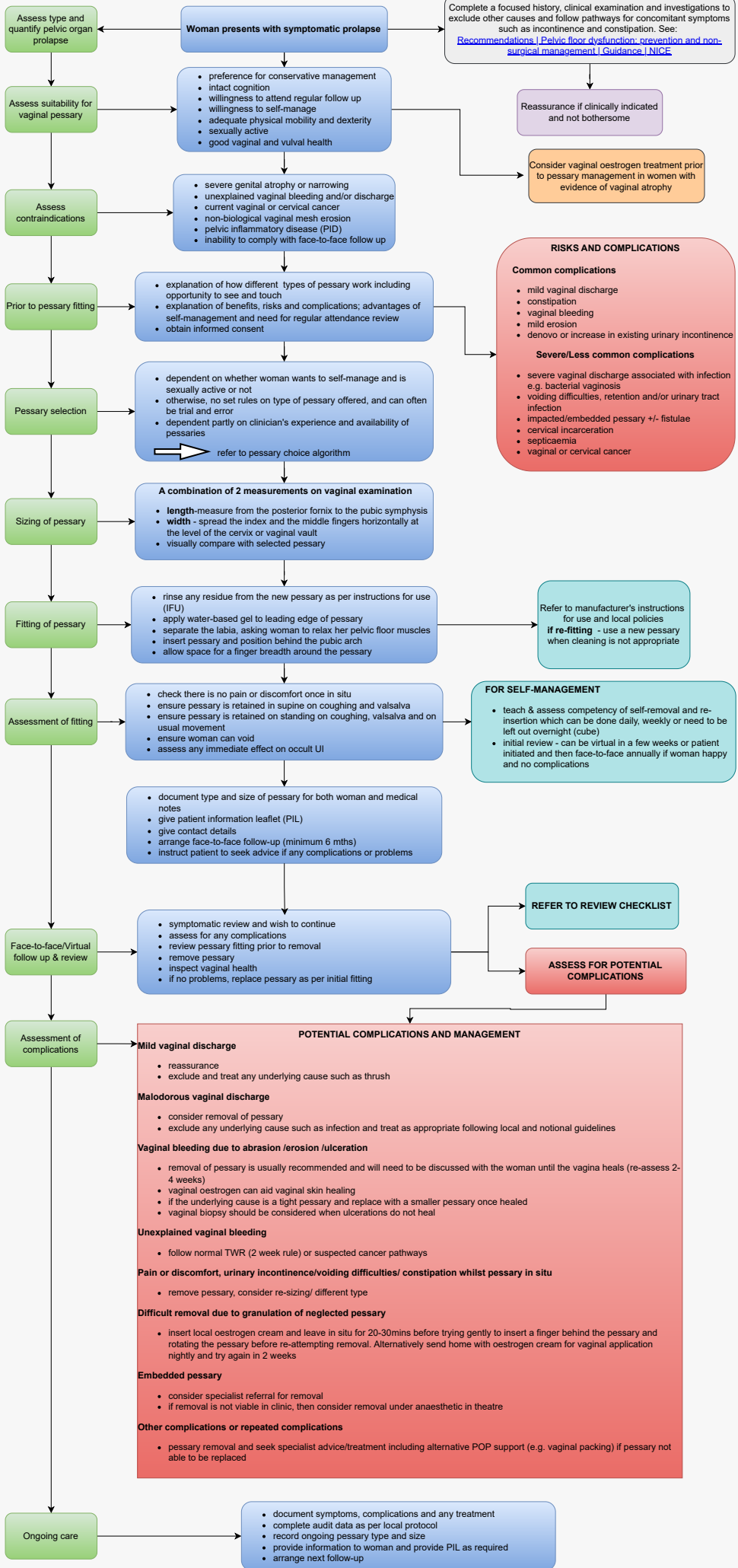


Clinical Pathway for Pessary Use for Prolapse



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, retention and non-surgical management | Guidance | NICE](#)

Reassurance if clinically indicated and not bothersome

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

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

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

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

REFER TO REVIEW CHECKLIST

ASSESS FOR POTENTIAL 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 national 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

• 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