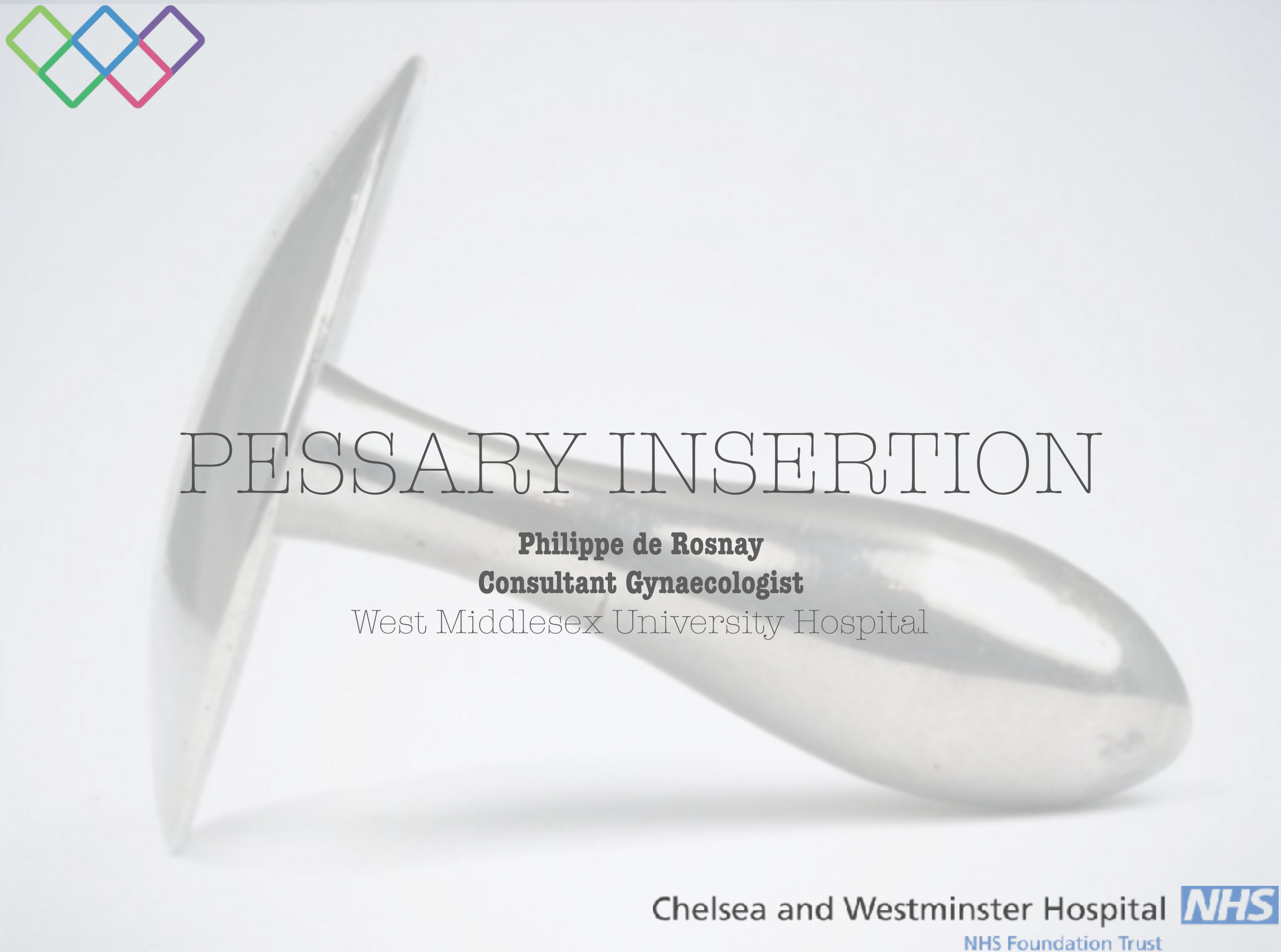

PESSARY INSERTION

Philippe de Rosnay
Consultant Gynaecologist
West Middlesex University Hospital

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

BACKGROUND

NHS Standard Contract 2015/16

Particulars – Ring Pessary

CCGs in North West London have begun the implementation of both Shaping a Healthier Future and each of their Out of Hospital (OOH) strategies. Shaping a Healthier Future is a

This service is aimed at women who need a ring pessary and is intended to enable the management, refitting and removal of ring pessaries to take place within Primary Care.

SESSION 1

- What is vaginal wall prolapse?
- Diagnosis and Management options
- Considerations in primary care & when to refer
- What do we offer at West Middlesex hospital?

SESSION 2

- Use of vaginal pessaries - tips & tricks
- Hands-on practise

WHAT IS VAGINAL WALL PROLAPSE?

- The descent of one or more of the:
    - anterior vaginal wall,
    - posterior vaginal wall,
    - the uterus/cervix or the apex of the vagina (post-hysterectomy)
- The presence of any such sign should be correlated with relevant POP symptoms.
- More commonly, this correlation would occur at the level of the hymen or beyond

Health & care information you can trust

Royal College of Obstetricians & Gynaecologists

Information for you

Published in March 2013 (next review date: 2016)

Pelvic organ prolapse

What is pelvic organ prolapse?

The organs within a woman's pelvis (uterus, bladder and rectum) are normally held in place by ligaments and muscles known as the pelvic floor. If these support structures are weakened by overstretching, the pelvic organs can bulge (prolapse) from their natural position into the vagina. When this happens it is known as pelvic organ prolapse. Sometimes a prolapse may be large enough to protrude outside the vagina.

This information is for you if you have been told that you have or if you think you may have a prolapse into the vagina. It explains what can cause prolapse and the various options for treatment.

It aims to help you understand the condition better to help you and your healthcare team make the best decisions about your care. It is not meant to replace advice from a doctor, nurse or physiotherapist about your own situation.

Key points

- Prolapse is very common. Mild prolapse often causes no symptoms and treatment is not always necessary. However, you should see your doctor if you think you may have a prolapse.
- Prolapse can affect quality of life by causing symptoms such as discomfort or a feeling of heaviness. It can cause bladder and bowel problems, and sexual activity may also be affected.
- Prolapse can be reduced with various lifestyle interventions interventions including stopping smoking, weight loss, exercise and avoiding constipation, as well as avoidance of activities that may make your prolapse worse such as heavy lifting.
- Treatment options to support your prolapse include physiotherapy, pessaries and surgery.
- How severe your symptoms are and whether you choose to have surgery will depend on how your prolapse affects your daily life. Not everyone with prolapse needs surgery but you may want to consider surgery if other options have not adequately helped.

https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/gynaecology/pi-pelvic-organ-prolapse.pdf

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SCOPE OF THE PROBLEM

- Objective findings of prolapse in the absence of relevant prolapse symptoms may be termed "**anatomic prolapse**".

- Approximately **half of all women** over the age of 50 years have been reported to complain of symptomatic prolapse.

- There is a **10% lifetime incidence** of undergoing surgery to correct symptomatic pelvic organ prolapse

PROLAPSE SYMPTOMS

- A departure from normal ***sensation*** (e.g. pressure/dragging feeling) or ***function*** (e.g. incomplete bladder emptying)
    - **in reference to the position of the pelvic organs.**
- Correlation with gravity (e.g. worsening after long periods of standing or exercise)
- May be more prominent at times of abdominal straining, e.g. defecation.

COMMON PROLAPSE SYMPTOMS

- Vaginal bulging
- Pelvic pressure
- Bleeding, discharge, infection
- Splinting/Digitation
- Low Back-ache

CLINICAL EXAMINATION

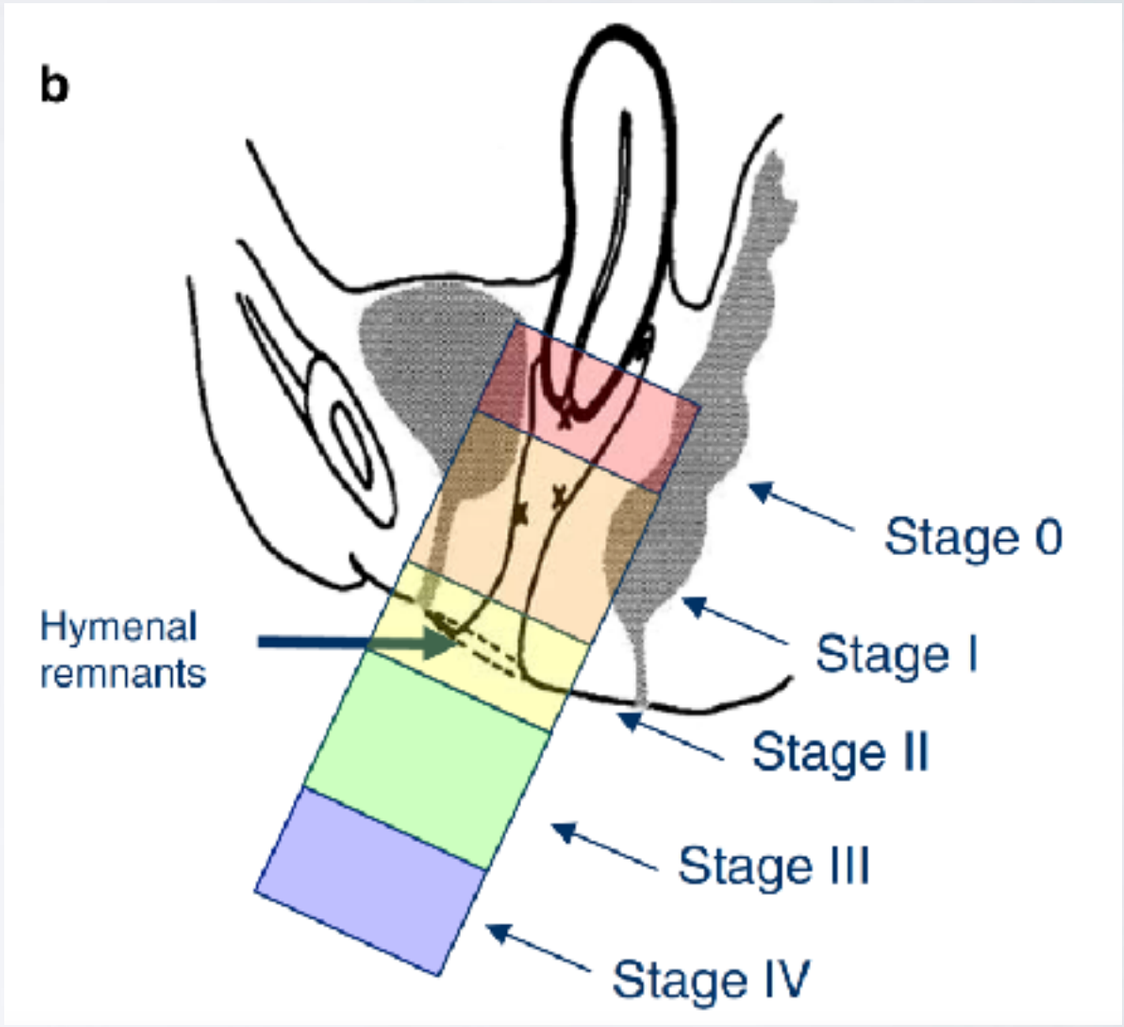
- Preferable if bladder empty (and if possible an empty rectum). *
- Which position during examination?**
- The hymen remains the fixed point of reference for prolapse description

CLASSIFICATION OF PROLAPSE

SAME LANGUAGE?

(MILD-MOD-SEVERE VS POP-Q)

- The POP quantification system (POP-Q) describes the topographic position of six vaginal sites.
- Subject of a review by the IUGA Standardisation and Terminology Committee with a view to simplification.
- No current consensus as to the interpretation of staging*



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PELVIC FLOOR MUSCLE FUNCTION -

IMPORTANT & EVOLVING SCIENCE
FUNDING HAS NOT KEPT PACE!

- Qualitatively defined* or use a validated grading symptom.

- **Assessment**: Voluntary pelvic floor muscle contraction and relaxation may be assessed by visual inspection, by digital palpation (circumferentially), electromyography, dynamometry, perineometry, or ultrasound.

- **Numerous factors** (e.g. strength, endurance, co-ordination) can be assessed **

- Desirable to document findings for **each side** of the pelvic floor separately to allow for any unilateral defects and asymmetry.

ICS report into the standardisation of terminology of pelvic floor muscle function and dysfunction

- (a) ***Normal pelvic floor muscles:*** pelvic floor muscles which can voluntarily and involuntarily contract and relax.

- (b) ***Overactive pelvic floor muscles:*** pelvic floor muscles which do not relax, or may even contract when relaxation is functionally needed, for example, during micturition or defecation.

- (c) ***Underactive pelvic floor muscles:*** pelvic floor muscles which cannot voluntarily contract when this is appropriate.

- (d) ***Non-functioning pelvic floor muscles:*** pelvic floor muscles where there is no action palpable.

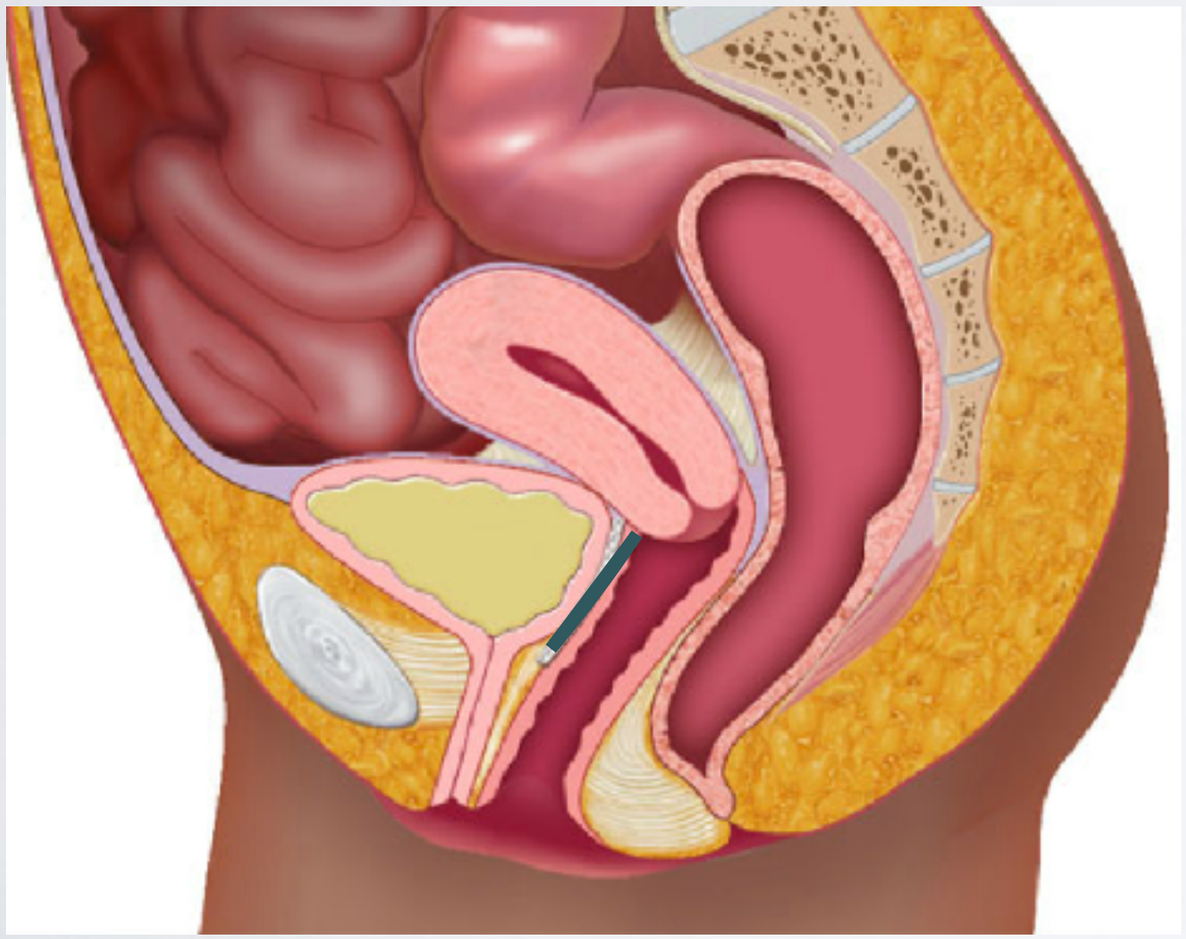
EXAMINATION FOR LEVATOR (PUBORECTALIS) INJURY

- By palpating its insertion on the inferior aspect of the os pubis.

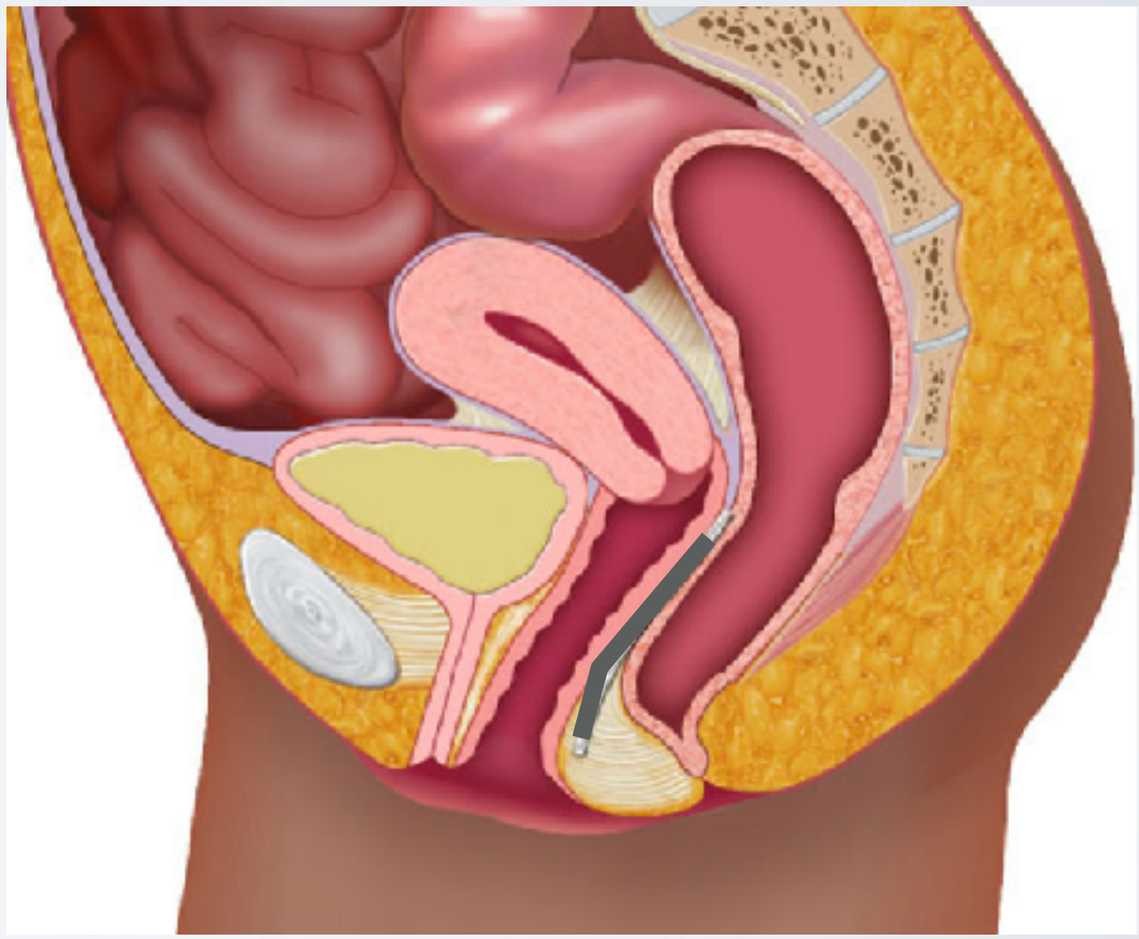
- If the muscle is absent 2–3 cm lateral to the urethra, i.e., if the bony surface of the os pubis can be palpated as devoid of muscle, an "avulsion injury" of the puborectalis muscle is likely

VAGINAL MESH

Anterior



Posterior



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MANAGEMENT OF POP

- ***Conservative measures:***
  - No active intervention i.e. 'wait and see'
  - Pelvic floor muscle training
  - Vaginal pessaries

Lifestyle changes:
-Managing obesity
-Managing chronic cough
-Smoking cessation
-Avoiding constipation
-Avoiding heavy lifting

- ***Surgery:***
  - Reconstructive (Native tissue or Mesh augmentation)
  - Excisional e.g. vaginal hysterectomy
  - Vaginal closure e.g. Colpocliesis

CONSIDERATIONS IN PRIMARY CARE & WHEN TO REFER

- If not bothersome, intervention usually unnecessary

- Explore conservative measures first e.g. weight loss and managing constipation

- Offer pelvic floor physio for supervised pelvic floor muscle training.

- Reasonable to initiate use of vaginal pessaries in primary care - **pessaries suitable for all stages of prolapse; generally less effective for rectocoele**

CONSIDERATIONS IN PRIMARY CARE & WHEN TO REFER

- Refer if:
  - No or little improvement with conservative Mx
  - Patient declines conservative Mx
  - Severe POP (Stage 3 or 4)
  - Complex presentations e.g. associated bladder, anorectal or sexual dysfunction
  - Recurrence after previous surgical Mx

What do we offer at West Middlesex hospital?

- Dedicated urogynae clinic
- Urodynamics
- Urogynae nurse specialist
- MDT meetings
- Pelvic floor physiotherapist (service commissioned by Hounslow CCG via HRCH NHS Trust)

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QUESTIONS?

SESSION 2

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USE OF VAGINAL PESSARIES: TIPS & TRICKS

- Types and composition of pessaries
- Indications & Contra-indications
- Patient assessment & insertion
- Follow-up and re-usable pessaries
- Patient self-management

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STANDARDS & GUIDELINES

- No consensus or universal standards to inform pessary choice or to optimise fitting success. 'Expert opinion' is the main driver.

- Practise is influenced by manufacturer guidelines, product availability, clinical judgment, and clinician or patient preferences.

- Massive variation regionally, nationally and internationally.

- Pessary fitting remains an art and a science with a degree of trial and error.

TYPES OF PESSARIES

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Focus on ring pessary

Most commonly used
Fits majority of women - 70%

Ring pessary & Ring with support membrane

Ring with knob & Ring with knob and support

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COMPOSITION

- Majority are latex-free

- Commonly used pessaries are either **Polyvinyl chloride (PVC) or Silicone**.

- **PVC** = synthetic plastic polymer.

  - Two basic forms: rigid and flexible e.g. Portex (brand-name).
    - disposed of within 6-12 months
    - relatively inexpensive

SILICONE

- Autoclavable
- Long shelf-life - can wash and re-use
- Less absorption of secretions/odours
- Easier to insert and remove
- More comfortable
- Lighter
- **.....BUT more expensive**

MECHANISM OF ACTION

- ***Supportive pessaries***
  - derive their support by a spring mechanism that rests in the posterior fornix and against the posterior aspect of the symphysis pubis
  - Support by the symphysis pubis is probably key.
  - Examples: Ring, Gehrung, Shaatz, Hodge

- ***Space-occupying pessaries****
  - supported by the creation of suction between the pessary and vaginal wall (e.g. cube)
  - or by providing a diameter larger than the genital hiatus (donut, InflatoBall)
  - or by both mechanisms (Gellhorn)

INDICATIONS FOR USE

- Patient preference for non-surgical alternative
- Significant comorbid risk factors for surgery
- Avoiding re-operation
- POP during pregnancy
- Desire for future pregnancy

CONTRA-INDICATIONS FOR PESSARY USE

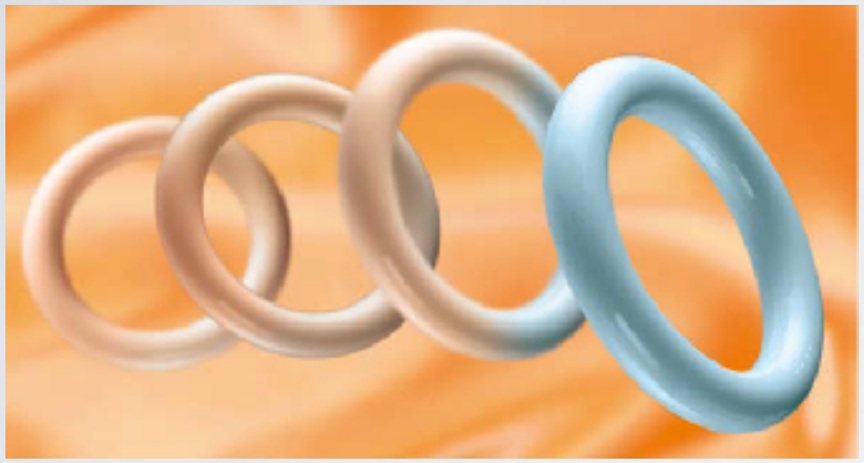
- Active genital tract infection

- Medical or social factors predisposing patient to non-compliance and pessary neglect

- Persisting vaginal ulceration/severe atrophy

  - Postmenopausal women likely to benefit from a short course of topical oestrogen before a pessary is fitted.

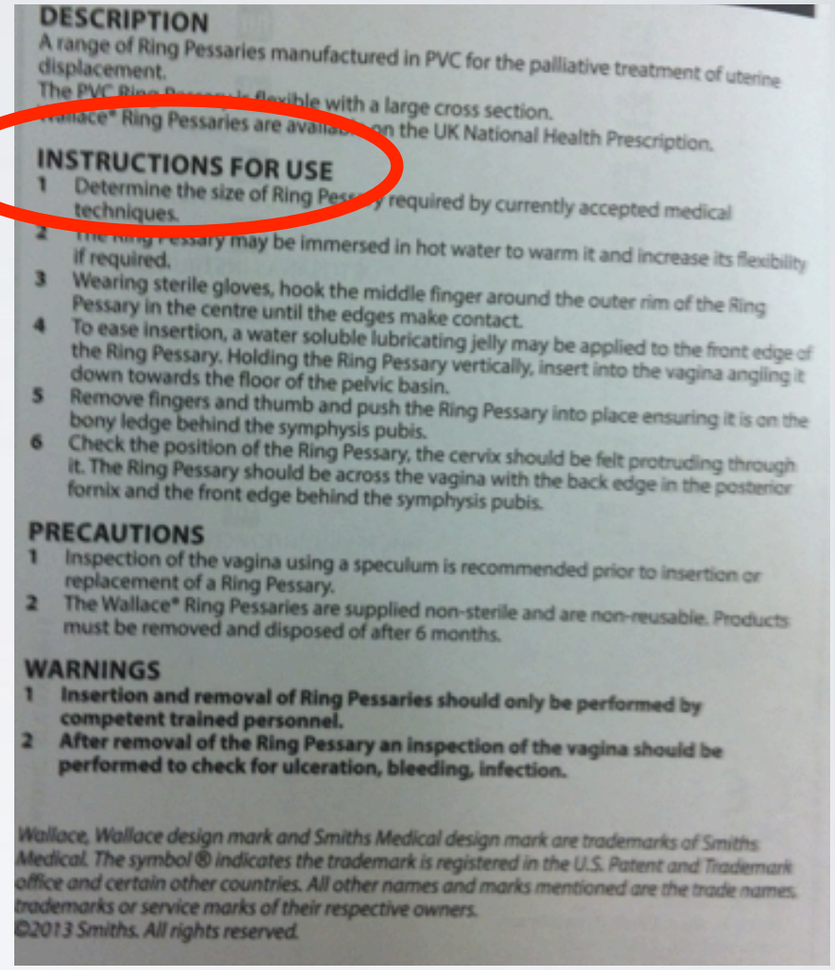
MANUFACTURERS



50 53 56 59 62 71 74 77 80 85 90 95 100 110

Sizes available (mm)

	Pessary	Prolapse (1 2 Degree)	Prolapse (2 3 Degree)	Cystocele	Rectocele	Stress Incontinence	Retro Displacement	Incompetent Cervix
	Cube		X	X	X			
	Cup	X		X		X	X	X
	Dish	X	X	X		X		
	Donut		X	X	X			
	Gellhorn		X	X	X			
	Gellhorn (Short Stem)		X	X	X			
	Gehrung		X	X	X			
	Hodge	X		X		X	X	X
	Mariwel		X	X				
	Oval	X		X				
	Ring	X		X				
	Ring w/ Knob	X	X	X		X		
	Shaatz		X	X				



DESCRIPTION

A range of Ring Pessaries manufactured in PVC for the palliative treatment of uterine displacement.

The PVC Ring Pessary is flexible with a large cross section.

Wallace® Ring Pessaries are available on the UK National Health Prescription.

INSTRUCTIONS FOR USE

1. Determine the size of Ring Pessary required by currently accepted medical techniques.
2. The Ring Pessary may be immersed in hot water to warm it and increase its flexibility if required.
3. Wearing sterile gloves, hook the middle finger around the outer rim of the Ring Pessary in the centre until the edges make contact.
4. To ease insertion, a water soluble lubricating jelly may be applied to the front edge of the Ring Pessary. Holding the Ring Pessary vertically, insert into the vagina angling it down towards the floor of the pelvic basin.
5. Remove fingers and thumb and push the Ring Pessary into place ensuring it is on the bony ledge behind the symphysis pubis.
6. Check the position of the Ring Pessary, the cervix should be felt protruding through it. The Ring Pessary should be across the vagina with the back edge in the posterior fornix and the front edge behind the symphysis pubis.

PRECAUTIONS

1. Inspection of the vagina using a speculum is recommended prior to insertion or replacement of a Ring Pessary.
2. The Wallace® Ring Pessaries are supplied non-sterile and are non-reusable. Products must be removed and disposed of after 6 months.

WARNINGS

1. **Insertion and removal of Ring Pessaries should only be performed by competent trained personnel.**
2. **After removal of the Ring Pessary an inspection of the vagina should be performed to check for ulceration, bleeding, infection.**

FITTING A PESSARY

- Discuss risks which include:
  - vaginal infection/discharge/odour
  - erosions/ulceration/bleeding → Contact person/number
  - **discomfort**
  - failure to reduce the prolapse,
  - expulsion
- Part labia and apply downward pressure with pessary to avoid traumatising urethra…don't over-lubricate!
- Communication with patient during insertion/removal…key moments!

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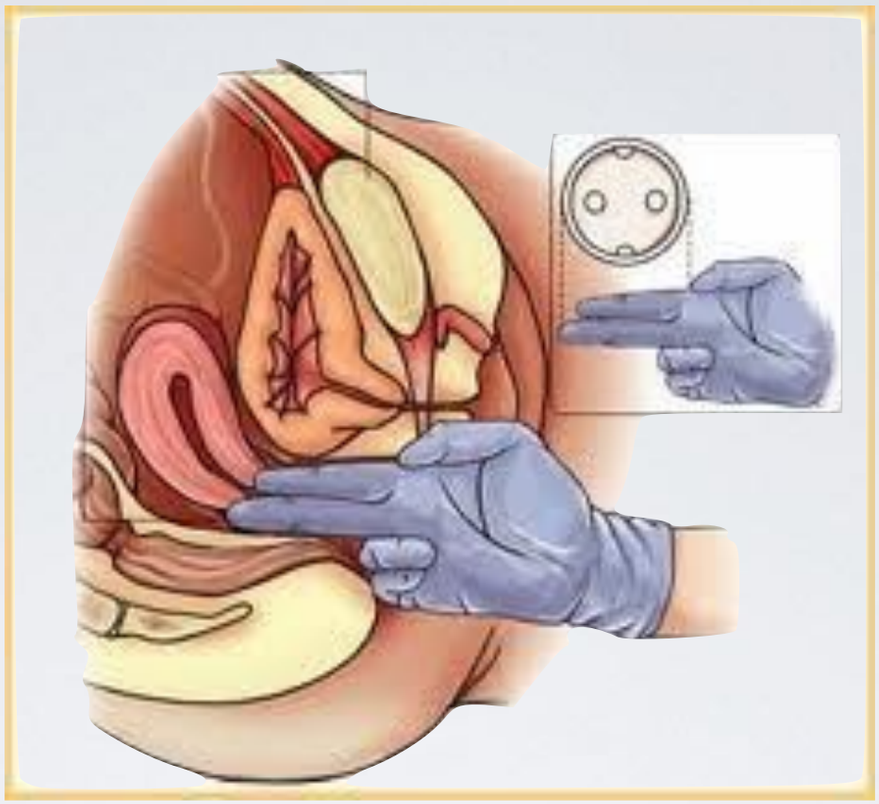

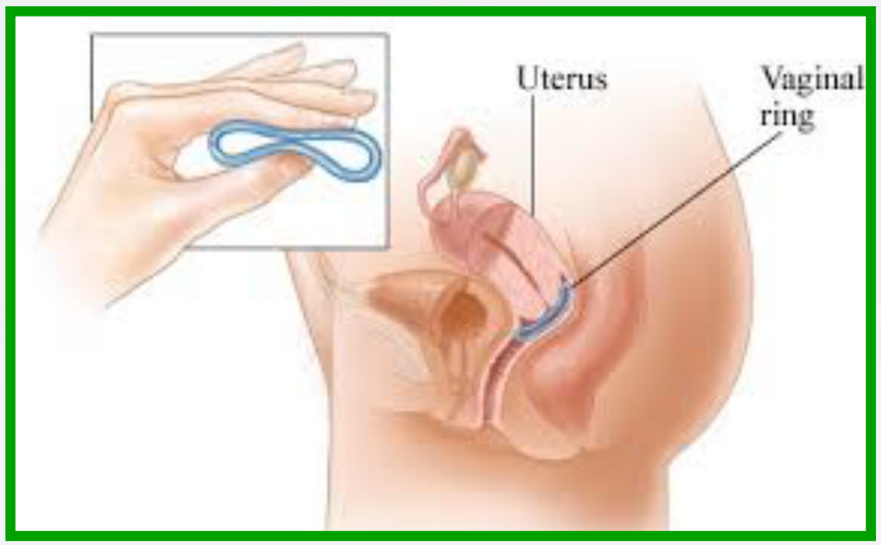

Lubricate & apply downward pressure
to avoid urethral trauma

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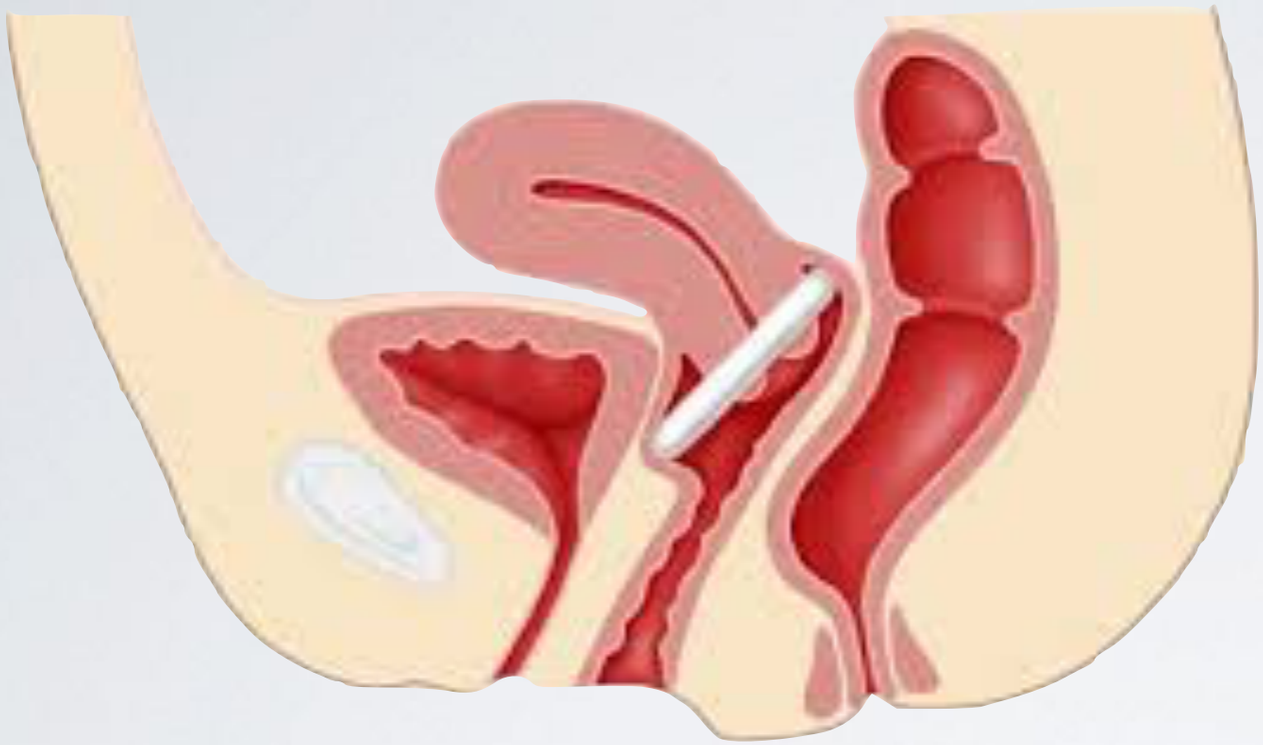
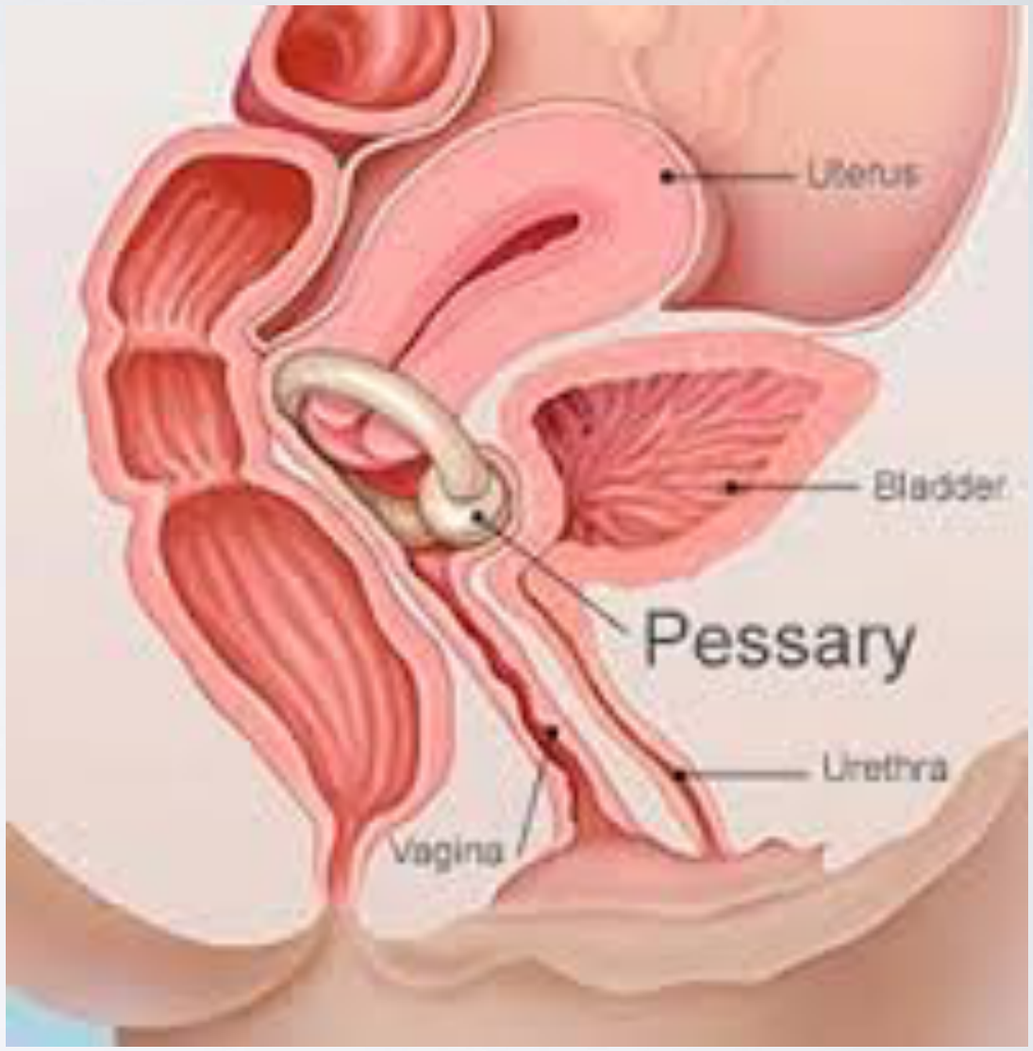
PESSARY IN-SITU





The average number of pessaries tried during a successful pessary fitting is two to three, typically at a single session.

Up to two follow-up fitting sessions have been reported prior to successful fitting.

Pessary Fitting Sets

-May need to try several sizes - don't size using silicone!

-Sterilise between patients

SEXUAL FUNCTION

- Little research to assess this specifically and clinical reports from individual couples vary greatly.

- Some styles (e.g. ring pessaries) are more likely to be comfortable for both partners during intercourse

- Alternatively, the pessary can be removed for intercourse either by the woman or her partner.

FREQUENCY OF PESSARY CHANGE

Data on recommended changing intervals are lacking

Journal of Obstetrics and Gynaecology, February 2009; 29(2): 129–131

informa
healthcare

GYNAECOLOGY

Evaluation of vaginal pessary management: A UK-based survey

M. GORTI[1,2], G. HUDELIST[1,3] & A. SIMONS[2]

Department of Obstetrics and Gynaecology, [1]Worthing Hospital, Worthing, [2]St Richards Hospital, Chichester, UK and [3]Villach Medical Center, Villach, Austria

Summary

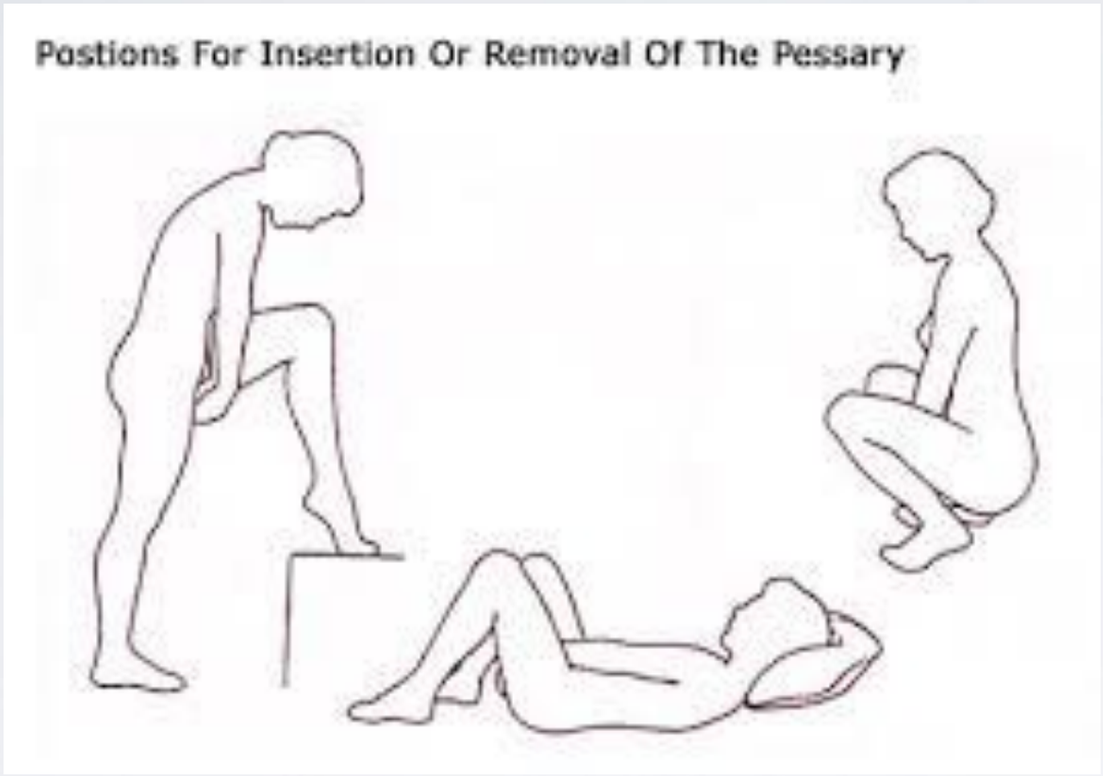
The use of intravaginal pessaries has been proven integral in the conservative treatment of pelvic organ prolapse (POP) and urinary incontinence (UI). Although there is no shortage of studies supporting the efficacy of intravaginal devices for conservative management of POP and UI and a large variety of pessaries are widely used in the UK, data on the clinical practice and recommended changing intervals are lacking. To evaluate the current clinical practice and management of patients with vaginal pessaries, self-administered questionnaires were mailed to all UK-based consultant obstetricians and gynaecologists. A total of 640 out of 1,173 (54.6%) clinicians approached returned the questionnaire, out of which 555 (86.7%) used vaginal pessaries. A total of 129 out of 555 (23.3%) clinicians claimed to change their patients pessaries every 3–6 months; 372 (67.0%) every 6 months and 54 (9.7%) reported a frequency of 6–12 months before changing the device. Complication rates of 40.3%, 35.2% and 18.5% were observed by clinicians performing 3–6 monthly, 6-monthly and up to 12-monthly changing intervals. Discontinuation of pessary use was related to recurrent involuntary expulsion in 54.0% (268/496), discomfort (27.4%, 136/49), vaginal bleeding and infection (7.8%, 39/496 clinicians) and dislike of the changing procedure (10.7%, 53/496). Changing intervals greatly vary between clinicians all over the country. The lack of differences in proportions of complications observed in 3-monthly and even up to 12-monthly observation periods suggest that 6-monthly and probably up to 12-monthly intervals represent a safe and cost-effective regimen to follow-up patients with vaginal pessaries.

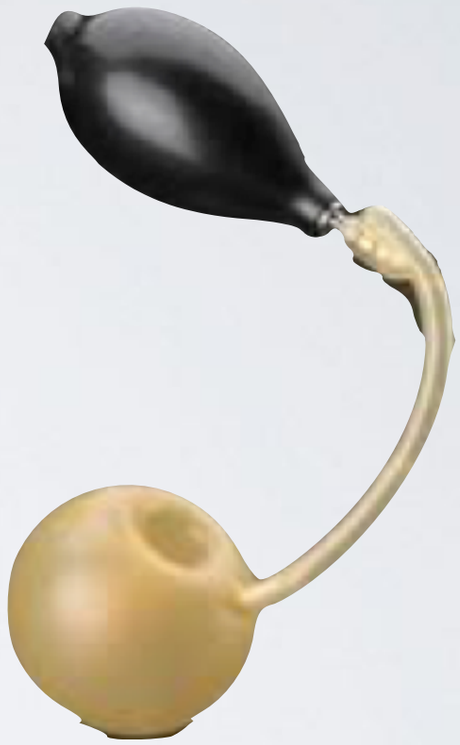
FREQUENCY OF PESSARY CHANGE

3-6 months	6 months	6-12 months
23%	67%	10%

'6-monthly and probably up to 12-monthly intervals represent a safe and cost-effective regimen to follow-up patients with vaginal pessaries'.

PATIENT SELF-MANAGEMENT





Pessaries designed to easily fold or deflate may be most amenable to self-insertion and removal.

BMJ Quality Improvement Reports

BMJ Quality Improvement Reports 2014; u206180.w2533 doi: 10.1136/bmjquality.u206180.w2533

Self-management of vaginal pessaries for pelvic organ prolapse

Rohna Kearney, Claire Brown
Cambridge University Hospitals NHS Trust

Abstract

Two thirds of women opt to use a vaginal pessary initially to manage the symptoms of pelvic organ prolapse. In the UK most women attend a health care professional at least every six months to change the pessary. This represents a significant burden both economically to the health care system and personally for the woman. Annually there are more than 300 appointments for pessary changes at our hospital. We developed a programme to teach women to self-manage their pessaries with the aim of improving patient experience and reducing outpatient attendances to free up outpatient capacity for new referrals. A physiotherapist was recruited to deliver this programme involving a one to one training session supplemented with written materials and an online video. Women using pessaries were offered the option of self-management.

Eighty-eight women aged between 29 to 84 years enrolled in the programme. Sixty-three women (73% of those enrolled) successfully continued with self-management at six months, creating 126 extra outpatient appointment capacity in one year alone. Women self-managing reported higher levels of convenience (94% vs 81%), accessibility (97% vs 73%), support (100% vs. 83%), and comfort (86% vs. 53%) than those attending the hospital for GP practice for pessary change.

Self-management appears to be an acceptable option for many women using vaginal pessaries, with personal benefits to the women and economic benefits to the hospital and commissioners.