Pelvic Prolapse:
Pessaries & More

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Pelvic organ prolapse is a common problem. A woman's lifetime risk of having surgery for prolapse or urinary incontinence is 11%.[1] The prevalence of moderate to severe prolapse in women presenting for routine gynecologic care was found to be greater than 50%.[2] Thus, the incidence of symptomatic pelvic organ prolapse lies between 11% and 55%. With the oldest of the baby boomer generation turning 60-years-old this year, physicians will undoubtedly have more patients presenting with prolapse.

What are the risk factors?

Risk factors for pelvic organ prolapse include:

- increasing age,
- race (Caucasians > African Americans),
- genetic factors (collagen),
- higher parity,
- prior hysterectomy,
- menopause,
- obesity,
- smoking and
- repetitive valsalva (chronic cough, chronic constipation, frequent heavy lifting).[3]

Sofie's Concern

- Sofie is a 68-year-old healthy grandmother.
- For years she has had a bulge "down there", but was too embarrassed to discuss it with you until now.
- Her history reveals that the bulge is now present at all times but is more prominent with coughing, lifting and prolonged standing.
- She feels the bulge when walking and sitting.
- She denies any vaginal bleeding or discharge.
- She denies any urinary incontinence; however, she has poor stream, incomplete emptying and often must manually reduce her bulge to void.
- She reports normal bowel movements and is not constipated.
- Due to her husband's poor health, she is not sexually active.
- Her abdominal exam reveals no palpable masses.
- Gynecologic examination of various compartments reveals a grade three cystocele, grade three uterine descent and grade two rectocele.
- You discuss management options with her, including observation, trial of pessary or surgery.
- Sofie wants something done about this bulge as it is interfering with her golf game, but she is deathly afraid of surgery.
- She decides she wants to try a pessary.

For more on Sofie, go to page 76.

More on Sofie

- You fit Sofie with a number 6 ring pessary with support.
- She finds it comfortable, it is not expelled with Valsalva and she is able to void prior to leaving the office.
- You see her a week later to assess her symptoms. The pessary keeps Sofie's prolapse well reduced. She has no vaginal bleeding or discharge and no new onset of urinary incontinence. In fact, she tells you that her bladder and golf game have never been so good.

What are the symptoms?

Women with pelvic organ prolapse may be asymptomatic if the prolapse is mild. Symptoms of pelvic organ prolapse may include pelvic pressure, pelvic heaviness, or an appreciable introital bulge. These symptoms may be exacerbated with increases in intra-abdominal pressure caused by:

- laughing,
- sneezing,
- coughing,
- straining,
- lifting, or
- prolonged standing.

Women with severe prolapse may have vaginal bleeding. This occurs because the stratified squamous epithelium of vaginal mucosa is not keratinized and may develop erosions or ulcers from chronically protruding through the introitus. This is caused from the pressure of sitting and the friction of walking.

Furthermore, patients with pelvic organ prolapse may have urinary symptoms ranging from stress incontinence (due to a hypermobile or an incompetent urethra) to voiding dysfunction, presenting with frequency, hesitancy, poor stream and incomplete emptying (due to urethral kinking). Patients may also have defecatory symptoms such as excessive straining or incomplete emptying.

Patients with urinary or defecatory problems may have to splint or manually reduce their prolapse in order to void or defecate. Due to embarrassment, patients rarely report splinting, so it is important for physicians to ask.

Physicians should also question their patients about the effects of their prolapse on sexual function. Women with prolapse may experience slackness (inability to feel penetration) due to a chronic prolapse increasing the introital diameter. Women may also experience urinary or fecal incontinence during intercourse and as a result refrain from sexual activity. Again physicians should ask these sensitive questions as part of a complete prolapse history.

FAQ 1

Do all women who wear pessaries need local estrogen?

Premenopausal women and postmenopausal women on systemic estrogen with well estrogenized vaginal mucosa will not need local estrogen. Local estrogen should be considered in all other patients in order to decrease vaginal ulcer formation. Local estrogen can be delivered as a cream, a tablet or a slow release ring, which generally fits within the diameter of a ring pessary.

Examining a patient with prolapse

An abdominal exam should be done to rule out any abdominal or pelvic masses. With the patient in the lithotomy position, the introitus and perineum are then examined for evidence of prolapse with the patient at rest and with Valsalva. A Sims speculum or split bivalve speculum is then used to assess the vaginal compartments individually, both at rest and with Valsalva for the presence and severity of prolapse (Figure 1).

The vaginal mucosa should also be assessed for the degree of estrogenization and the presence of ulcers. The vagina is divided into three compartments:

1) Anterior compartment:
   - Cystocele
   - Urethrocele
2) Middle compartment:
   - Uterine/cervical stump
   - Vaginal vault
   - Enterocele
3) Posterior compartment:
   - Rectocele

Patients can suffer from prolapse in one or more compartments. The severity of prolapse is commonly graded as follows:

- grade 1 – descent to midpoint of vagina,
- grade 2 – descent to the introitus,
- grade 3 – prolapse through the introitus.

The grade of prolapse is that observed with maximum Valsalva. The presence and severity of prolapse of each compartment should be recorded. Although the Pelvic Organ Prolapse Quantification system (POP-Q) provides a standardized technique with quantitative measurements, it is not commonly used in clinical practice due to its complexity.[4]

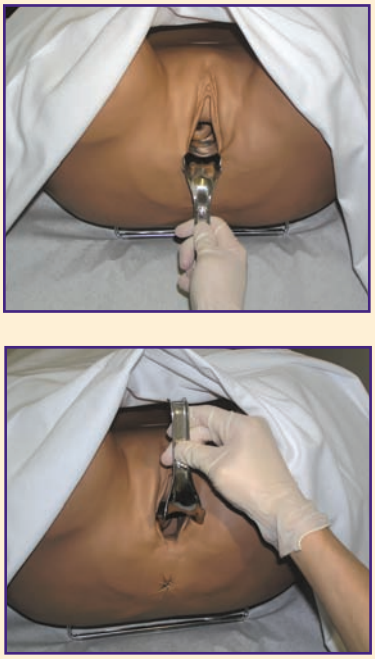

Figure 1. Assessing anterior, middle and posterior compartments with a split speculum.

What is the procedure for fitting the pessary?

Once the type and severity of prolapse has been established, a two digit vaginal examination is done to determine the vaginal width. Based on the vaginal width, the size of fitting ring or pessary is chosen. Choosing a ring pessary with support is a good place to start (Figure 2). This versatile pessary will address most isolated anterior or middle compartment prolapse, as well as multiple compartment prolapse.

Once the pessary is in place, ask the patient

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FAQ 2

There are so many pessaries available, how can I possibly stock them all?

Pessaries come in numerous styles (*i.e.,* ring, ring with support, ring with knob, donut, Gellhorn, cube, *etc.*) and sizes. Providing pessary care doesn't need to be complicated. For example, physicians can purchase a pessary fitting kit (it is essentially identical to a diaphragm fitting kit). Or, they can keep three pessaries in stock (*i.e.,* ring pessary with support: sizes 4, 5 and 6) (Figure 2). These will work for over 70% of patients. Both the pessary fitting rings and pessaries themselves can be autoclaved.

Figure 2. Most commonly used pessary: size 4, 5 and 6 with ring support.

if she is comfortable. A properly fitted pessary is not discernable to the patient. Then ask the patient to bear down. With Valsalva, the pessary will move down a little (Figure 3). If however, the pessary is partially or completely expelled from the vagina, it is too small and the next size up should be tried. After an initial pessary fitting, or any increase in the size of the patient's pessary, the patient should be asked to void prior to leaving the office. A pessary that is too large may obstruct the urethra and cause urinary retention.

Pessary fitting may be difficult or unsuccessful in patients with a short vagina (less than seven centimetres) or a wide introitus (greater than four fingerbreadths).[5] Women with isolated posterior compartment defects generally do poorly with ring pessaries as the rectocele tends to bulge below the pessary. Patients presenting with vaginal erosions or ulcers should have these treated with a local estrogen cream that is generally applied nightly for two to four weeks prior to a pessary fitting. Similarly, a patient who develops ulcers from her pessary should have the pessary removed, the ulcer treated with local estrogen, then be reassesed to ensure the ulcers have healed before having the pessary reinserted.

FAQ 3

What are the complications of using pessaries?

As long as patients see their physicians on a regular basis for pessary care, or do regular self care, serious complications are rare. However, if this does not occur, neglected pessaries can become incarcerated and can cause vesicovaginal fistulas or rectovaginal fistulas.

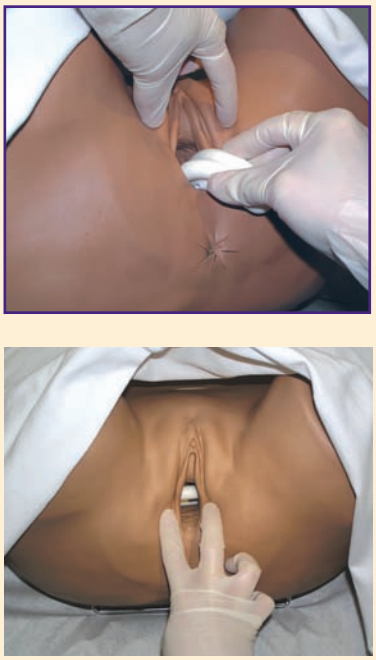

Figure 3. Inserting a ring pessary with support and assessing fit.

Follow up

After the initial pessary fitting, or after a change to a different pessary, the patient should be seen in one to two weeks to reassess her symptoms. If the pessary is addressing her prolapse and there are no new concerns (*i.e.,* discharge, bleeding or urinary incontinence), the patient can be seen every three months for the first year and every six months thereafter for ongoing pessary care.[6]

Pessary care involves assessing symptoms, removing the pessary, examining the vaginal mucosa for erosions or ulcers with a speculum, rinsing the pessary with warm water and reinserting it.

The patient can be taught pessary self-care. This can be done by showing her, with a mirror, how to remove and reinsert the pessary. It is important to observe her as she removes and reinserts the pessary to ensure proper technique and placement.

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Take-home message

- Pelvic organ prolapse is common and will be increasingly common with an aging population with a longer life expectancy.
- Pessaries are an effective non-surgical option for many patients with pelvic organ prolapse.
- Physicians providing pessary care should stock ring pessaries with support sizes 4, 5 and 6 as these pessaries address most patients' needs.
- Other pessary styles and sizes can be ordered as needed, through manufacturers websites or from local pessary representatives.

References

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Net Readings

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