1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Loretta M. Vasquez-Findlay

DOB
12/03/1954

AGE / SEX
71 yrs / Female

MRN / PATIENT ID
UG-33507

DATE OF SERVICE
08/20/2026

PROVIDER
Gerald T. Okpara, MD

CREDENTIALS
MD — Female Pelvic Medicine & Reconstructive Surgery

PRIMARY OB-GYN PROVIDER
None current — discharged from routine care at 68

VISIT TYPE
Pessary visit with follow-up — 3-month check, refitting for erosion, surgical decision

CARE SETTING
Outpatient Urogynecology Clinic, hospital-based pelvic floor center

PRIMARY CARE PROVIDER
Renata Sowande, MD

REFERRING PROVIDER
Primary care — vaginal bulge and recurrent urinary tract infections

INTERPRETER USED
None required

CHAPERONE PRESENT
Yes — Denise Kowalczyk, RN, throughout the pelvic examination and pessary management

CC CHIEF COMPLAINT

2 PRIMARY UROGYNECOLOGY CONCERN

"The ring has helped the bulge enormously — I can walk the dog again without feeling like something is falling out. But I've had a brownish discharge for about three weeks, and I'm still leaking when I cough or lift my grandson. I want to talk about whether surgery would just fix all of it."

S SUBJECTIVE

3 URINARY, PELVIC FLOOR, BOWEL & PROLAPSE SYMPTOMS

3a REASON FOR EVALUATION & URINARY SYMPTOMS

Reason for Urogynecology Evaluation

Third visit (initial 02/2026, pessary fitted 05/2026). Purposes today: (1) routine 3-month pessary check with evaluation of a 3-week history of brown vaginal discharge, (2) reassessment of persistent stress urinary incontinence now unmasked by prolapse reduction, (3) review of recurrent urinary tract infection frequency since pessary placement, and (4) definitive discussion of surgical repair versus continued pessary management.

Urinary Incontinence Symptoms

Stress-predominant mixed incontinence. Leakage with coughing, sneezing, laughing, and lifting her 3-year-old grandson — roughly 4–6 episodes daily, small to moderate volume, requiring 3 pads per day (moderate absorbency, changed for wetness rather than routinely). **Notably worse since the pessary was fitted**, which she initially found discouraging until it was explained; before the pessary she leaked 1–2 times daily. Also has urge-related leakage 1–2 times weekly — a sudden compelling need with an inability to reach the toilet in time, particularly on returning home and putting the key in the door. No continuous leakage. Minimal post-void dribbling. Impact: she has stopped attending her Thursday choir practice and avoids long car journeys.

Urinary Urgency / Frequency Symptoms

Urgency present but not dominant — a moderate sudden need roughly 4 times daily, with leakage on 1–2 occasions weekly. Daytime voiding interval 2–2.5 hours, giving 7–8 daytime voids. **Nocturia 2 per night**, from 1 a year ago; she attributes it to fluid timing and it disrupts her sleep on approximately half of nights. No bladder spasms. Triggers identified: 3 cups of coffee before noon and 2 diet colas daily (both caffeine and artificial sweetener), and fluids taken after 8 pm. Key-in-door urgency is a classic learned trigger.

Voiding Dysfunction / Emptying Symptoms

Before the pessary she had to **splint (push the bulge back with her fingers) to empty her bladder** — a hallmark of obstructive anterior prolapse. That has entirely resolved since fitting. Currently: no hesitancy, a normal stream, no straining, no double voiding, and a subjective sense of complete emptying. No retention episode and no catheterisation ever. Post-void residual measured today (below) and at the fitting visit — both normal.

Recurrent UTI History

Four culture-proven urinary tract infections in the 12 months before pessary placement (07/2025, 10/2025, 12/2025, 02/2026), and **one since** (06/2026). Organisms: *Escherichia coli* ×4 (all pan-sensitive except one with trimethoprim-sulfamethoxazole resistance) and *Klebsiella pneumoniae* ×1. Treated with nitrofurantoin ×3, cephalexin ×1, and ciprofloxacin ×1. Symptoms have been dysuria, frequency, and cloudy malodorous urine — **never fever, flank pain, or rigors**, so no pyelonephritis. Not related to intercourse (not sexually active). Never on prophylaxis. **Not on vaginal estrogen — the significant and correctable gap**, given that atrophy is a major driver of recurrent infection in this age group. No prior urologic evaluation, no cystoscopy, no upper-tract imaging.

3b PROLAPSE, PAIN, BOWEL & PELVIC FLOOR

Pelvic Organ Prolapse Symptoms

Before the pessary: a constant sensation of a vaginal bulge with visible tissue protrusion by the end of each day, heaviness and dragging pelvic pressure, worse with standing, walking, and lifting, and relieved by lying down; she had to splint to void and occasionally to defecate. She had stopped walking her dog and gardening. **Since the pessary (05/2026) the bulge sensation and pressure have resolved almost completely** — she rates the improvement as 9 out of 10, has resumed dog-walking and light gardening, and describes it as “the single best thing anyone has done for me.” She has noticed the brown discharge for 3 weeks and no longer feels tissue protrusion at all.

Pelvic Pain / Bladder Pain Symptoms

No suprapubic, pelvic, urethral, or bladder pain. No pain with bladder filling and no relief with voiding — the pattern that would suggest bladder pain syndrome is absent. Dysuria only during infections. No dyspareunia (not sexually active). **No pessary-related pain**, which she was specifically asked about, as pain would demand immediate removal. No flare pattern. No prior treatment for pelvic pain.

Bowel Symptoms

Chronic constipation, long-standing and undertreated — a significant contributor to her prolapse. Stools every 2–3

days, Bristol type 2 (hard lumps), with straining on most occasions and a sense of incomplete evacuation. Before the pessary she needed to splint the posterior vaginal wall to complete a bowel movement; this has improved but not resolved. **No fecal incontinence and no gas incontinence** — asked directly, as these are commonly concealed. No rectal bleeding. Small external hemorrhoids, occasionally itchy. Current regimen: over-the-counter docusate taken irregularly, roughly twice weekly, plus prunes — inadequate. Fiber intake low; fluid intake modest.

Pelvic Floor Symptoms

Awareness of pelvic floor weakness rather than tightness. Taught Kegel exercises by a nurse in the 1990s after her second delivery, never formally instructed, and has not performed them in decades — **and on examination today she was contracting incorrectly, recruiting gluteal and abdominal muscles**. No spasm, no difficulty relaxing, no tampon intolerance. **Never referred for pelvic floor physical therapy** — a substantial gap in her care. No prior therapy and therefore no response to assess.

Sexual Health

Not currently sexually active — widowed 6 years ago, and she volunteered without prompting that she is not seeking a new relationship and that sexual function is not a treatment goal for her. Vaginal dryness present but asymptomatic day to day. No dyspareunia (no intercourse). Prolapse had affected her body image and confidence rather than her sexual function. No trauma history. **Her stated goals are continence, comfort, and staying active — not sexual function**, and this materially affects the surgical options that are appropriate to discuss (including obliterative procedures).

3c OBSTETRIC, DEVICE & TREATMENT HISTORY

Gynecologic / Obstetric History

Postmenopausal since age 51, natural, **never used hormone therapy** — 20 years of unopposed atrophy. No vaginal bleeding since menopause until the current brown discharge (which is being evaluated today). **Uterus in situ — no hysterectomy. P4: four spontaneous vaginal deliveries** (1976, 1978, 1981, 1985), birth weights 7 lb 9 oz, 8 lb 4 oz, **9 lb 6 oz**, and 8 lb 1 oz. **One forceps delivery (1981, the 9 lb 6 oz infant) with a third-degree perineal tear repaired at the time** — the single most important obstetric risk factor in her history. Midline episiotomy with the first delivery. No cesarean. No pelvic surgery of any kind. No endometriosis, no fibroids. No hormone therapy, systemic or vaginal.

Pessary History

Ring pessary with support, size 4, fitted 05/12/2026 — her first, after two unsuccessful trial sizes at that visit (size 3 expelled with Valsalva, size 5 uncomfortable). In continuous use for 14 weeks. **Benefit excellent** — bulge resolved, splinting to void resolved, activity restored. Comfort good with no pain. Retention reliable, with no expulsion even with straining at stool or lifting her grandson. **Problems: brown vaginal discharge for approximately 3 weeks, mild and not malodorous, and no bleeding that she has seen. She has not been removing or cleaning it at all** — she was shown self-management at fitting but reports she "couldn't reach it and was afraid of doing damage," so it has been in situ for 14 weeks continuously without removal. No odor. This is the likely explanation for the discharge and is the finding that needed examining today.

Prior Treatments

Pessary (05/2026, ongoing, excellent for prolapse). **Kegel exercises** — taught informally in the 1990s, never performed since, and performed incorrectly today. **Nothing else has been tried:** no bladder training, **no pelvic floor physical therapy**, no overactive bladder medication, **no vaginal estrogen**, no bulking agent, no botulinum toxin, no neuromodulation, no sling, no prolapse repair, no UTI prophylaxis, and no structured bowel regimen. She is essentially conservative-therapy-naive apart from the pessary — which means there is a great deal of low-risk benefit still available before surgery.

Medication and Allergy History

Amlodipine 5 mg daily (hypertension). Atorvastatin 40 mg daily. Metformin 1,000 mg twice daily (type 2 diabetes). Alendronate 70 mg weekly (osteoporosis). Levothyroxine 50 mcg. Docusate 100 mg PRN, taken irregularly. Acetaminophen PRN for knee osteoarthritis. Calcium and vitamin D3 1,000 IU. **No diuretic** — specifically confirmed, as it would worsen frequency and nocturia. **No anticholinergic or beta-3 agonist ever tried. No vaginal estrogen. No anticoagulant** (relevant to surgical planning). No opioids or other constipating agents beyond her baseline. **Allergy: penicillin — childhood rash, non-urticarial, no anaphylaxis** (documented for antibiotic selection). Full adherence, no cost barrier, Medicare with supplemental coverage.

Medical / Surgical History

Type 2 diabetes since 2011, HbA1c 7.3% — relevant to recurrent infection, wound healing, and neuropathic bladder risk. Hypertension, controlled. Hyperlipidaemia. Hypothyroidism, euthyroid. **Osteoporosis (T-score –2.7 in 2024)** on alendronate. Bilateral knee osteoarthritis limiting deep squatting. **Chronic constipation as above.** Obesity, BMI 32.1 — an independent prolapse and incontinence risk factor. **No chronic cough** — asked specifically, and she has never smoked. No neurologic disease: no multiple sclerosis, no Parkinson disease, no stroke, no spinal stenosis or disc disease, no back surgery. No sleep apnea. No inflammatory bowel disease. No pelvic radiation. No kidney stones. **No prior pelvic or abdominal surgery, no hysterectomy, no sling, and no mesh of any kind** — a surgically naive pelvis, which simplifies any future repair. Cholecystectomy declined in 2019 for asymptomatic gallstones. Two general anaesthetics in the past (dental, 1970s) without complication.

Fluid / Dietary Factors

Total fluid approximately 1.4 L daily — modest, and she has been **deliberately restricting fluid to reduce leakage**, which is counterproductive and contributes to both constipation and concentrated irritative urine. **Caffeine: 3 cups of coffee before noon plus 2 diet colas daily** — a substantial and readily modifiable bladder irritant load, compounded by the artificial sweetener. No alcohol. Carbonated beverages as noted. Occasional spicy food without symptom correlation. Most fluid taken in the morning with little after 6 pm, yet nocturia persists at 2 — suggesting it is not purely behavioural. Low fiber intake: no legumes, 1–2 vegetable servings daily, white bread.

Lifestyle and Functional Impact

Retired bookkeeper, widowed 6 years, lives alone in a single-storey home. **Activity substantially restored by the pessary** — she walks her dog twice daily and gardens again. Remaining limitations are driven by **incontinence rather than prolapse**: she has stopped Thursday choir practice, avoids car journeys over an hour, maps toilets before going out, and uses 3 pads daily. Mild vulvar skin irritation from pad use. Sleep disrupted on about half of nights by nocturia. Cares for her 3-year-old grandson two afternoons weekly, including lifting him — a specific and important functional goal. No caregiver needs; independent in all activities of daily living. **Stated goals, in her own priority order: stop the leaking, keep the bulge away, stop the infections, and be able to lift her grandson.**

Pertinent Negatives

Denies gross hematuria at any time, including during infections. No fever, chills, flank pain, or rigors — no episode has ever suggested pyelonephritis. No severe or recurrent complicated infection requiring hospitalisation. No urinary retention and no catheterisation. No severe pelvic pain and no pessary-related pain. **No new neurologic deficit** — no leg weakness, numbness, saddle anaesthesia, gait change, or back pain, so no cauda equina or neurologic bladder concern. **No postmenopausal bleeding that she has observed** (brown discharge is being evaluated). No unexplained weight loss, no night sweats. No rapidly worsening symptoms.

ROS UROGYNECOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Urinary storage and leakage	**Positive: stress leakage 4–6×/day (worse since pessary), urge leakage 1–2×/week, frequency 7–8 daytime voids, nocturia 2, 3 pads/day. Negative for dysuria between infections, gross hematuria, and incomplete emptying.**
Prolapse	**Positive historically: constant bulge, tissue protrusion, pelvic heaviness, splinting to void and defecate — all resolved with the pessary. Negative currently for bulge sensation and protrusion.**
Infection and bladder pain	**Positive: 4 culture-proven UTIs in 12 months pre-pessary, 1 since. Negative for fever, flank pain, bladder or suprapubic pain, pain with filling, urethral pain, and retention.**

Bowel	**Positive: chronic constipation, Bristol 2, stools every 2–3 days, straining, incomplete evacuation, prior posterior splinting, external hemorrhoids.** Negative for fecal incontinence, gas incontinence, and rectal bleeding.
Vaginal and pessary	**Positive: brown vaginal discharge for 3 weeks; pessary never removed or cleaned in 14 weeks; vaginal dryness.** Negative for pessary pain, odor, visible bleeding, and expulsion.
Neurologic	**Negative for leg weakness, numbness, saddle anaesthesia, gait change, and back pain — no neurologic bladder or cauda equina concern. Diabetic neuropathy screening negative on examination.**
Systemic infection	**Negative for fever, chills, rigors, flank pain, nausea, and vomiting. No episode has ever suggested upper-tract infection.**
Psychosocial and quality of life	**Positive: embarrassment about leakage, withdrawal from choir, toilet-mapping behaviour, sleep disruption, pad-related vulvar irritation. Negative for depression (PHQ-9 5), anxiety (GAD-7 4), and social isolation beyond the choir.**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
98.1 °F

BLOOD PRESSURE
136/78 mmHg

HEART RATE
76 bpm, regular

RESPIRATORY RATE
16/min

OXYGEN SATURATION
97% on room air

HEIGHT
5′ 2″ (157 cm)

WEIGHT
176 lb (79.8 kg)

BMI
32.1 kg/m²

PAIN SCORE
0/10 — no pelvic or pessary-related pain

5a GENERAL & SYSTEMIC EXAMINATION

General Appearance

Alert, pleasant, well groomed, no distress. Obese habitus with central distribution. Ambulates independently with a mildly antalgic gait attributable to knee osteoarthritis; no aid used. Well hydrated. Sits and rises from the chair without assistance. Cooperative and forthcoming, including about the symptoms she found embarrassing.

Cardiovascular

Rate 76 and regular, S1 and S2 normal, no murmur. Peripheral pulses 2+ and symmetric; pedal pulses palpable. Capillary refill brisk. **Trace bilateral ankle edema**, symmetric, attributable to amlodipine and dependency — relevant, as dependent

fluid mobilised at night contributes to nocturia. No calf tenderness or unilateral swelling. No jugular venous distension.

Pulmonary

Normal effort, clear to auscultation bilaterally, no wheeze or crackles. **No cough elicited on examination and no history of chronic cough** — specifically documented, since chronic cough is a major driver of both prolapse recurrence and stress incontinence and its absence is favourable for surgical durability. Never smoked. Room air.

Abdomen

Obese, soft, non-distended, non-tender. **No suprapubic tenderness and no palpable bladder distension** — consistent with the normal post-void residual. No mass, no organomegaly. Bowel sounds normal. No guarding or rebound. **No surgical scars — a surgically naive abdomen and pelvis.** No hernia at the umbilicus or inguinal regions. Palpable stool in the left lower quadrant consistent with her constipation.

Back / Flank

No costovertebral angle tenderness bilaterally — assessed given the recurrent infections, and its absence argues against upper-tract involvement. No spinal tenderness, step, or deformity. Lumbar range of motion mildly reduced by age and habitus. No sacral dimple or hair tuft. No signs of spinal pathology to suggest a neurogenic bladder.

5b PELVIC & PERINEAL EXAMINATION

External Genitalia / Vulva

Marked genitourinary atrophy of menopause — labia minora resorbed, pale thin vulvar skin with loss of subcutaneous bulk, narrowed introitus, and reduced elasticity, consistent with 20 years of postmenopausal change without any estrogen. **Mild erythema and superficial excoriation of the labia majora and perineum from pad contact**, no ulceration, no candidal satellite lesions, no cellulitis. No lichen sclerosus (no architectural loss with white sclerotic change beyond atrophy, no fissuring). **Urethral meatus atrophic and patulous with a small urethral caruncle**, non-tender, no discharge. No lesion or mass. Perineal body thinned with a well-healed midline scar from the 1981 third-degree tear repair. No prolapse visible at rest with the pessary in situ.

Speculum Exam

Pessary removed first (see Pessary Assessment) before mucosal assessment, since the device conceals precisely the tissue that must be inspected. After removal: vaginal mucosa **markedly atrophic** — pale, thin, smooth, non-rugated, friable, with reduced calibre requiring the narrowest speculum. **A single 6 mm shallow, clean-based erosion on the right lateral vaginal wall at the level of the pessary rim, with a granulating base and a small amount of old brown blood but no active bleeding, no purulence, no undermined edges, and no induration** — the explanation for her discharge. **No ulceration elsewhere and no mesh exposure (she has none).** Cervix atrophic, smooth, non-friable, os stenotic, **no lesion and no contact bleeding** — specifically examined given the discharge. No discharge beyond old blood. With the pessary out and on Valsalva, prolapse descended promptly (POP-Q below).

Bimanual Exam

Uterus present, small and atrophic, anteverted, mobile, non-tender, no mass. **Descends readily with Valsalva — the apical component.** Adnexa: no mass or tenderness bilaterally (limited by habitus, though no mass was appreciated). **Pelvic floor: markedly reduced resting tone with weak voluntary contraction; on request she recruited gluteal and abdominal muscles instead of the levator — she is performing Kegels incorrectly and always has been.** No levator tenderness or spasm. **No bladder or urethral tenderness** — assessed and negative, arguing against bladder pain syndrome and against urethral diverticulum.

Pelvic Organ Prolapse Exam

Performed with the pessary removed, in the dorsal lithotomy position with maximal Valsalva, and repeated standing to confirm maximal descent. POP-Q: Aa +2, Ba +4, C +1, gh 5.0, pb 2.5, tvl 8.5, Ap +1, Bp +1, D –1. Interpretation: **stage III anterior compartment prolapse (cystocele) with stage II apical (uterine) descent and stage II posterior compartment prolapse (rectocele)** — a multi-compartment defect with the anterior wall dominant. Fully reducible manually with no incarceration. Descent was greater standing than supine, as expected. **With the prolapse reduced digitally, cough stress testing demonstrated leakage — occult stress incontinence unmasked by reduction**, which is precisely why her leakage worsened after the pessary was fitted and is the single most important finding for surgical planning.

Cough Stress Test

Performed twice, prolapse reduced digitally, in the supine position with a comfortably full bladder (approximately 250 mL by patient report, post-void residual then measured). **Positive — immediate visible spurt of urine from the urethral meatus coincident with each cough, on both attempts.** Repeated standing: also positive with a larger volume. This is objective demonstration of stress urinary incontinence with urethral hypermobility, not urgency-driven leakage. Limitation: bladder volume estimated rather than instilled, and testing was not performed with the pessary in situ.

Neurologic / Pelvic Reflexes

Perineal sensation intact and symmetric to light touch and pinprick in all sacral dermatomes — no saddle anaesthesia. **Anal wink present bilaterally. Bulbocavernosus reflex present.** Lower-extremity strength 5/5 proximally and distally. **Monofilament sensation intact at all 10 plantar sites bilaterally — no diabetic peripheral neuropathy**, specifically assessed given 15 years of type 2 diabetes and its association with neuropathic bladder. Deep tendon reflexes 2+ and symmetric, ankle jerks present. Gait antalgic from knee arthritis but stable; Romberg negative. **No neurologic explanation for her urinary symptoms.**

Rectal Exam

Performed with consent and chaperone present. **Anal sphincter resting tone normal and squeeze pressure mildly reduced but symmetric** — assessed carefully given the 1981 third-degree tear and forceps delivery, with no palpable sphincter defect and no keyhole deformity, consistent with her intact continence to stool and gas. **Rectocele confirmed on rectovaginal palpation, corresponding to the POP-Q posterior findings. Moderate hard stool burden in the rectal vault** — objective corroboration of her constipation. No mass, no tenderness. Small non-thrombosed external hemorrhoids. **No blood; stool brown and occult-blood negative.** No fissure.

Skin

Mild irritant contact dermatitis of the vulva and perineum from pad occlusion — erythema with superficial excoriation, no ulceration, no satellite lesions to suggest candidiasis, no cellulitis. No pressure injury. No wounds or surgical scars apart from the perineal repair. No bruising. Groin skin folds intact without intertrigo despite obesity and diabetes.

PF PELVIC FLOOR / PROLAPSE ASSESSMENT

6 PELVIC FLOOR & PROLAPSE FINDINGS

POP-Q measurements	**Aa +2, Ba +4, C +1, gh 5.0, pb 2.5, tvl 8.5, Ap +1, Bp +1, D −1 (cm relative to the hymen, maximal Valsalva, confirmed standing). Genital hiatus widened at 5.0 cm and perineal body thinned at 2.5 cm, both consistent with her obstetric history.**
Compartment involvement	**Multi-compartment: anterior (dominant), apical, and posterior. Anterior wall descends 4 cm beyond the hymen; cervix 1 cm beyond; posterior wall 1 cm beyond.**
Prolapse stage	**Stage III anterior (cystocele), stage II apical (uterine descent), stage II posterior (rectocele). Overall stage III by the leading edge.**
Reducibility	**Fully reducible manually without difficulty. No incarceration, no ulceration of the prolapsed segment beyond the single rim erosion, and no keratinisation.**
Stress incontinence with prolapse reduced	**Positive — occult stress urinary incontinence unmasked by reduction, demonstrated on cough stress testing both supine and standing. The single most consequential finding of this visit: it explains why the pessary worsened her leakage, and it means any prolapse repair must include a concurrent continence procedure or she will be**

	worse off.
Pelvic floor tone	Reduced at rest, without hypertonicity or spasm. No levator tenderness.
Pelvic floor strength	**Modified Oxford grade 1 of 5 — a flicker of contraction only, and non-sustained.** She recruited gluteal and abdominal muscles on request, confirming that she does not know how to isolate the levator — despite believing she had been doing Kegels correctly for decades.
Levator tenderness or spasm	None. No myofascial trigger points, no obturator or levator tenderness — this is a weakness rather than an overactivity problem, which determines the physiotherapy approach.
Vaginal atrophy / tissue quality	**Marked atrophy — pale, thin, friable, non-rugated mucosa with reduced calibre, after 20 years postmenopausal with no estrogen exposure.** Poor tissue quality is directly implicated in the pessary erosion, in her recurrent infections, and in the durability of any surgical repair.
Mesh exposure or surgical changes	**None — no prior prolapse repair, no sling, no mesh of any kind.** Surgically naive pelvis with only the 1981 perineal repair scar. This is favourable: no mesh complication risk to consider and normal tissue planes for any future surgery.
Functional impact	Voiding: obstructive splinting resolved by the pessary; leakage worsened by it. Bowel: posterior splinting improved but constipation persists. Sexual: not applicable by her choice. Quality of life: prolapse symptoms largely resolved, but **incontinence is now the dominant complaint** — PFDI-20 remains elevated at 96 despite the prolapse subscale falling markedly.

BV BLADDER / VOIDING ASSESSMENT

7 URINARY FUNCTION ASSESSMENT

Urinalysis (today)	Clear yellow. **Leukocyte esterase trace, nitrites negative, blood negative, protein negative, glucose negative,** specific gravity 1.020. Microscopy: 5–10 WBC/hpf, no RBC, occasional squamous cells, **no bacteria seen.** Consistent with mild atrophy-related pyuria rather than active infection; she is asymptomatic.
Urine culture status	**Sent today for completeness given the trace pyuria, but she is asymptomatic and no antibiotic was started** — treating asymptomatic bacteriuria in an older woman causes harm without benefit, and this was explained to her explicitly. Prior cultures: *E. coli* ×4 (one trimethoprim-sulfamethoxazole resistant), *K. pneumoniae* ×1, all otherwise pan-sensitive with no extended-spectrum beta-lactamase organism.
Post-void residual	**42 mL by bladder scan** after a spontaneous void of approximately 260 mL — normal, with no evidence of incomplete emptying or obstruction. Prior at fitting

	(05/2026): 55 mL. Reassuring and important, as it excludes overflow incontinence and confirms the pessary is not causing obstruction.
Bladder diary review	**3-day diary completed and brought in.** Total intake 1,380 mL/day (low, and deliberately restricted). **Caffeine 3 coffees plus 2 diet colas daily.** Daytime voids 7–8 at 2–2.5 hour intervals, average voided volume 180 mL (small), **nocturia 2**, largest single void 320 mL (adequate functional capacity). Leakage episodes 5–6 daily, of which 4–5 were activity-related (cough, sneeze, lift) and 1 urgency-related — **objectively confirming stress-predominant mixed incontinence.**
Pad count / pad weight	3 moderate-absorbency pads daily, changed for wetness. Formal pad-weight testing not performed — the diary and positive cough stress test are sufficient and pad testing would add little.
Cough stress test	**Positive supine and standing with the prolapse reduced** — immediate visible leakage coincident with cough on all attempts. Objective demonstration of stress incontinence with urethral hypermobility.
Uroflowmetry	Not performed today. Not indicated given a normal post-void residual, a normal stream by history, and no obstructive symptoms since the pessary. Would be obtained as part of formal urodynamics if she proceeds toward surgery.
Urodynamic study	**Not yet performed — and now indicated.** Ordered today, because she has mixed symptoms with a demonstrable occult stress component unmasked by reduction, and she is contemplating surgery: it is important to quantify the stress component, assess detrusor overactivity, exclude impaired detrusor contractility (which would raise post-operative retention risk after a sling), and measure valsalva leak point pressure before committing to a continence procedure.
Cystoscopy	Not performed and not currently indicated — no gross hematuria at any time, no microscopic hematuria today, no sterile pyuria pattern, no bladder pain, and no suspicion of a foreign body or fistula. Would be indicated for hematuria, refractory urgency after adequate therapy, or suspicion of intravesical pathology.
Hematuria evaluation status	**Not required.** No gross hematuria historically and no microscopic hematuria on today's urinalysis. Documented deliberately to record that hematuria was assessed and excluded rather than overlooked in a 71-year-old.
Voiding pattern, triggers, functional limitations	Small-volume frequent voiding (average 180 mL) with adequate maximum capacity — a behavioural and irritant-driven pattern rather than reduced capacity. Triggers: high caffeine and artificial sweetener load, key-in-door learned urgency, and coughing, sneezing, and lifting for the stress component. Limitations: choir abandoned, long car journeys avoided, toilet-mapping, 3 pads daily, sleep disrupted by nocturia twice nightly.

PS PESSARY ASSESSMENT

8 PESSARY EVALUATION & MANAGEMENT — PERFORMED TODAY

Pessary type and size	**Ring pessary with support, size 4**, fitted 05/12/2026. In continuous use for 14 weeks.
Indication	Symptomatic stage III anterior with stage II apical and posterior prolapse, in a patient who wished to avoid surgery at that time.
Fit and retention	Fit appropriate for the device chosen — retained reliably through Valsalva, straining at stool, and lifting, with no expulsion in 14 weeks. However, **the rim was seated firmly against markedly atrophic right lateral vaginal wall tissue**, which is what produced the erosion.
Comfort and symptom improvement	**Excellent for prolapse** — bulge and pressure resolved, splinting to void resolved, activity restored, patient-rated 9 of 10. No pain at any time. **But it unmasked her occult stress incontinence**, so overall symptom benefit is mixed: prolapse much better, continence worse.
Removal and reinsertion	**Removed today by the provider** — she has never removed it herself. Removal atraumatic after applying lubricant; the device was coated with a small amount of old brown discharge and debris. Vaginal walls then inspected fully (findings above). **Not reinserted immediately** — see the refitting decision below.
Vaginal tissue inspection	**Single 6 mm shallow, clean-based, granulating erosion on the right lateral vaginal wall at the rim contact point, with old brown blood and no active bleeding, purulence, undermining, or induration.** Surrounding mucosa markedly atrophic, pale, thin, and friable. No ulceration elsewhere, no fistula, no granulation tissue mass. Cervix normal without lesion or contact bleeding.
Erosion, bleeding, discharge, odor, infection	**Erosion present as described — this is the cause of the 3-week brown discharge.** Discharge was scant, brown (old blood), and **not malodorous**, with no purulence and no surrounding cellulitis — so no infection. No active bleeding. Importantly, no features suggesting malignancy: the base is clean and granulating, edges are not heaped or indurated, and there is no mass.
Cleaning performed	Pessary washed with soap and warm water and inspected — intact, no cracking, discolouration, or deformity. Retained by the clinic pending the healing interval rather than returned to the patient.
Self-care ability and cleaning schedule	**The root cause of the erosion: she has not removed or cleaned the device once in 14 weeks.** She was shown self-management at fitting but could not reach the device and feared causing damage. Limited by obesity, knee arthritis restricting positioning, and reduced confidence — not by cognition or dexterity. **Continuous 14-week retention in atrophic, unestrogenised tissue is precisely the setting in which erosion occurs.**
Need for refitting, replacement, temporary removal, or vaginal estrogen	**Decision made and explained: pessary removed and held out for 2–3 weeks to allow the erosion to heal, with**

vaginal estrogen	**out for 2–3 weeks to allow the erosion to heal, with vaginal estrogen started now. Refitting thereafter — likely to a Gellhorn or a ring with knob, which distributes pressure differently, or the same ring if the tissue improves substantially on estrogen. She will have symptomatic prolapse during the interval, which was discussed and accepted; a support garment and activity modification were advised. Vaginal estrogen is not optional here — it is required both to heal this erosion and to prevent the next one, and its absence is the single correctable factor underlying both the erosion and her recurrent infections.**
Patient education and follow-up interval	**Self-management retaught with a mirror, in a modified position accommodating her knees, and with a removal-hook device provided; she succeeded in removing and reinserting a practice device twice today, which she had never previously managed. Written instructions with diagrams provided. New schedule: remove weekly overnight, wash, and reinsert in the morning — giving the tissue a regular rest interval. Return in 3 weeks for erosion review and refitting; thereafter every 3 months if self-managing well.**

PR PROCEDURES PERFORMED

9 PROCEDURE DOCUMENTATION

Procedure, indication, consent, chaperone, anaesthesia

Four procedures performed: (1) **pessary removal with vaginal wall inspection and device cleaning** — indicated by 3 weeks of brown discharge in a patient with 14 weeks of continuous unremoved wear; (2) **POP-Q staging with prolapse reduction and cough stress testing** — indicated for surgical planning and to test for occult stress incontinence; (3) **post-void residual measurement by bladder scan** — to exclude retention and pessary-related obstruction; (4) **urine specimen collection**. Verbal consent obtained for each with explanation. Chaperone Denise Kowalczyk, RN present throughout. No anaesthesia required; topical lubricant only.

Technique, specimens, findings

Pessary removed digitally after lubrication, atraumatically. Full speculum inspection of all vaginal walls with the narrowest speculum given atrophy and reduced calibre. POP-Q measured in dorsal lithotomy at maximal Valsalva and **confirmed standing**, using a marked measuring device at all nine points. Cough stress test performed twice with the prolapse digitally reduced, supine and standing, with a comfortably full bladder. Post-void residual by portable bladder scanner after a spontaneous void. Rectovaginal examination for sphincter integrity and rectocele. **Specimens: clean-catch urine for urinalysis and culture. No biopsy taken** — the erosion has a clean granulating base without heaped or indurated edges or mass, features that are reassuring; biopsy would be indicated if it fails to heal after 4–6 weeks of estrogen and pessary rest. Findings as documented in the Objective and Pessary sections. **Pessary not reinserted** — deliberately held out for healing.

Tolerance, complications, aftercare, follow-up

All procedures well tolerated with mild discomfort only on speculum insertion, attributable to atrophy. **No complications** — no bleeding beyond the pre-existing old blood, no vasovagal episode, no trauma on removal. Self-management retaught with a practice device and a removal hook, with two successful patient-performed removals and reinsertions. Aftercare in writing: begin vaginal estrogen tonight; expect the return of bulge symptoms while the pessary is out and use a support garment; nothing per vagina other than the estrogen; report **increasing discharge, malodour, fresh bleeding, pain, fever, or inability to pass urine**. Follow-up in 3 weeks for erosion review and refitting.

ST SCREENING / ASSESSMENT TOOLS

10 STANDARDIZED TOOLS & INTERPRETATION

Pelvic Floor Distress Inventory (PFDI-20)	**96 of 300 — moderate-to-severe distress. Prior 02/2026: 164. The fall is driven almost entirely by the prolapse subscale (POPDI 64 to 14); the urinary subscale has risen (UDI-6 42 to 58), quantifying exactly what she describes: prolapse better, leakage worse.**
Pelvic Floor Impact Questionnaire (PFIQ-7)	**81 of 300 — moderate impact, down from 148. Residual impact is now predominantly urinary, affecting travel, social activity (choir), and sleep.**
ICIQ (incontinence)	**ICIQ-SF 14 of 21 — severe. Increased from 9 pre-pessary, objectively confirming that prolapse reduction unmasked stress incontinence.**
Overactive Bladder Questionnaire	**OAB-q symptom bother 34 of 100 — mild-to-moderate. Present but clearly secondary to the stress component, which matters for treatment sequencing.**
Bladder diary	**3 days completed: intake 1,380 mL/day (restricted), 5 caffeinated drinks daily, 7–8 daytime voids averaging 180 mL, nocturia 2, maximum void 320 mL, and 5–6 leakage episodes daily of which 4–5 were activity-provoked. Objectively stress-predominant mixed incontinence with a modifiable irritant load and counterproductive fluid restriction.**
Urinary Distress Inventory (UDI-6)	**58 of 100 — moderate-to-severe, risen from 42. Stress items score highest.**
Incontinence Severity Index	**8 of 12 — severe (frequent leakage of moderate volume). 3 pads daily corroborates.**
POPDI-6 (prolapse subscale)	**14 of 100 — mild, down from 64. The clearest single measure of how well the pessary worked for prolapse.**
Female Sexual Function Index	**Not administered — not sexually active and she stated sexual function is not a treatment goal. Documented because it directly widens her surgical options, including obliterative procedures.**
Constipation assessment	**Rome IV criteria met for functional constipation. Bristol type 2, stools every 2–3 days, straining and incomplete evacuation on most occasions, with prior posterior splinting. Wexner fecal incontinence score 0 — fully continent to stool and gas despite the 1981 third-degree tear, consistent with the intact sphincter on examination.**
Pain scale	**0/10. No pelvic, bladder, or pessary-related pain at any point — a relevant negative, as pessary pain would mandate immediate removal and different management.**
PHQ-9 / GAD-7	**PHQ-9 5 (mild), GAD-7 4 (minimal). Embarrassment and social withdrawal from the choir are present without a mood disorder. Item 9 = 0.**
Social determinants of health screening	**Negative for food, housing, transportation, and utility insecurity. Medicare with supplemental coverage. Lives alone in a single-storey home, independent in all activities**

alone in a single-storey home, independent in all activities of daily living, with adult children nearby.

L LABORATORY AND DIAGNOSTIC RESULTS

11 RESULTS REVIEWED OR ORDERED

Urine Testing

Urinalysis today: trace leukocyte esterase, nitrites negative, blood negative, protein negative, glucose negative, specific gravity 1.020; microscopy 5–10 WBC/hpf, no RBC, no bacteria. **Urine culture sent, but she is asymptomatic and no antibiotic was started** — treating asymptomatic bacteriuria in older women confers harm without benefit, and this was explained. **Prior culture trend:** 07/2025 *E. coli* pan-sensitive; 10/2025 *E. coli* trimethoprim-sulfamethoxazole resistant; 12/2025 *E. coli* pan-sensitive; 02/2026 *K. pneumoniae* pan-sensitive; 06/2026 *E. coli* pan-sensitive. **No extended-spectrum beta-lactamase organism and no multidrug resistance** — favourable. No urine cytology (no hematuria, no smoking history, no indication).

Bladder / Urodynamic Testing

Post-void residual 42 mL today after a 260 mL void (55 mL at the 05/2026 fitting) — normal, excluding retention and pessary-related obstruction. **Cough stress test positive supine and standing with the prolapse reduced.** 3-day bladder diary as detailed above. **Multichannel urodynamics ordered today** — not previously performed, and now indicated before any continence procedure to quantify the stress component, detect detrusor overactivity, exclude impaired detrusor contractility that would raise post-sling retention risk, and measure valsalva leak point pressure. No uroflowmetry, cystometrogram, pressure-flow study, urethral pressure profile, or cystoscopy to date. No pad-weight testing (diary and cough test sufficient).

Imaging

None performed and none currently indicated — documented deliberately. Renal and bladder ultrasound not required: post-void residual is normal, there is no obstruction, no hydronephrosis risk, and no upper-tract infection (no fever, no flank pain, no costovertebral tenderness at any point). CT urogram not indicated in the absence of hematuria or stone history. MRI pelvis and pelvic floor ultrasound not indicated — POP-Q clinical staging is the standard and imaging would not change management. Defecography not indicated: her constipation is functional (Rome IV positive with a hard stool burden) and would be reconsidered only if it persists after an adequate bowel regimen and physiotherapy.

Gynecologic Testing

Pap and HPV co-test 2018 — negative cytology, HPV-negative; screening appropriately discontinued at 65 and not repeated. **No endometrial biopsy performed — and this was considered explicitly:** the brown discharge is fully accounted for by a visible pessary erosion with a clean granulating base, the cervix is normal without lesion or contact bleeding, and there has been no true postmenopausal bleeding. **However, if the discharge persists or any fresh bleeding occurs after the erosion heals, transvaginal ultrasound with endometrial assessment and biopsy will be mandatory** — and she was told this in plain terms. No vaginal culture (no purulence, no odor, no candidal features). No STI testing (not sexually active).

Bowel / Pelvic Floor Testing

No anorectal manometry — not indicated: she is fully continent to stool and gas (Wexner 0) with an intact sphincter on examination despite the 1981 third-degree tear. **No defecography** — her rectocele is clinically evident and her constipation is functional; imaging would not alter first-line management. **Colonoscopy 2019 normal** (records reviewed), next due 2029; no alarm features to warrant earlier repeat, and today's occult blood was negative. **No prior pelvic floor physical therapy evaluation — referral placed today**, which will provide the first formal assessment of her levator function.

Prior Records Reviewed

Our own initial consultation 02/2026 (POP-Q at that visit: Aa +2, Ba +4, C +2, Ap +1, Bp +1 — essentially unchanged) and the 05/2026 pessary fitting note documenting two failed trial sizes and the size 4 ring with support. Primary care records 2024–2026 with all five urine culture results, antibiotic courses, HbA1c trend, and the 2024 DEXA (T-score –2.7). 2019

colonoscopy report (normal). 1981 obstetric record confirming forceps delivery and third-degree perineal tear repair. Pharmacy fill history confirming adherence and **confirming no vaginal estrogen has ever been dispensed**. Her 3-day bladder diary. **No urology, prior sling, prolapse repair, mesh, or pelvic floor physiotherapy records exist — she is treatment-naive in all of these respects.**

A ASSESSMENT

12 UROGYNECOLOGY CLINICAL INTERPRETATION

- **Multi-compartment pelvic organ prolapse — stage III anterior (cystocele), stage II apical (uterine descent), stage II posterior (rectocele)** by POP-Q, unchanged from February. Risk factors are classic and additive: four vaginal deliveries including a 9 lb 6 oz forceps delivery with a third-degree tear, chronic constipation with chronic straining, obesity (BMI 32.1), age 71, and 20 years of unestrogenised atrophy. Symptomatically **very well controlled by the pessary** — POPDI-6 fell from 64 to 14 and she has resumed dog-walking and gardening.
- **Stress-predominant mixed urinary incontinence, and this is now her dominant problem.** Objectively established: cough stress test positive supine and standing with the prolapse reduced, ICIQ-SF 14 (severe), Incontinence Severity Index 8 of 12, 3 pads daily, and a diary showing 4–5 of 5–6 daily leakage episodes are activity-provoked. The urgency component is real but secondary (OAB-q 34).
- **The central mechanistic insight: her prolapse was masking her stress incontinence, and reducing it with the pessary unmasked it.** This is why her leakage worsened after a device that otherwise helped her greatly, it explains her frustration, and it is the finding that dictates surgical planning — a prolapse repair alone would leave her worse off, so any repair must include a concurrent continence procedure. Her ICIQ-SF rising from 9 to 14 after fitting is the objective footprint of this.
- **Pessary-related vaginal erosion — a single 6 mm shallow, clean-based, granulating lesion at the rim contact point on the right lateral wall**, fully accounting for 3 weeks of brown discharge. **Cause is clear and correctable: 14 weeks of continuous wear without a single removal, in markedly atrophic, unestrogenised tissue.** Reassuring features — clean granulating base, no heaped or indurated edges, no mass, no malodour, no purulence, no cellulitis. Malignancy is unlikely but is not dismissed: if it fails to heal on estrogen with the pessary out, biopsy is mandatory.
- **Genitourinary syndrome of menopause — the single most correctable factor in her entire presentation, and it has never been treated.** Twenty years postmenopausal with no estrogen exposure of any kind. It is directly implicated in three separate problems: the pessary erosion, the recurrent urinary tract infections, and the likely durability of any surgical repair. That no clinician has offered vaginal estrogen is the most consequential gap in her care.
- **Recurrent uncomplicated urinary tract infections — four in the 12 months before the pessary, one since.** Contributors: marked atrophy with loss of the protective vaginal microbiome, prolapse with prior incomplete emptying requiring splinting (now resolved), diabetes with an HbA1c of 7.3%, and low fluid intake. Favourably, **all cultures are sensitive with no resistant organism, there has never been fever or flank pain, post-void residual is normal, and no upper-tract or anatomic abnormality is suspected** — so no imaging or cystoscopy is required, and vaginal estrogen is the highest-yield intervention.
- **Chronic functional constipation (Rome IV positive) with a rectocele** — Bristol type 2, stools every 2–3 days, chronic straining, prior posterior splinting, and a moderate hard stool burden palpable on rectal examination. This is both a cause and a consequence of her prolapse, and it is currently treated with irregular docusate alone. **Left unaddressed, chronic straining will undermine any surgical repair.**
- **Severe pelvic floor muscle weakness that has never been properly treated** — modified Oxford grade 1 of 5, with incorrect recruitment of gluteal and abdominal muscles when asked to contract. She has believed for thirty years that she was doing Kegels correctly. **She has never been referred for pelvic floor physical therapy**, which is first-line, evidence-based, low-risk therapy for both stress incontinence and mild-to-moderate prolapse.

- **Modifiable behavioural contributors are substantial and untouched:** five caffeinated drinks daily including two artificially sweetened colas, a total intake of only 1,380 mL because she is deliberately restricting fluid to reduce leakage (which concentrates irritative urine and worsens constipation), and a learned key-in-door urgency trigger. None has been addressed.
- **Differential considered and excluded:** neurogenic bladder (excluded — intact perineal sensation, present anal wink and bulbocavernosus reflex, normal monofilament testing with no diabetic peripheral neuropathy, no back or neurologic symptoms); overflow incontinence (excluded — post-void residual 42 mL); bladder pain syndrome (excluded — no pain with filling, no relief with voiding, no bladder or urethral tenderness); urethral diverticulum (no tenderness or mass); vesicovaginal fistula (excluded — no continuous leakage, and the vaginal walls were fully inspected); bladder or vaginal malignancy (no hematuria, no mass, erosion base benign in character — though biopsy remains the contingency); fecal incontinence from her obstetric sphincter injury (excluded — Wexner 0, intact sphincter on examination); and anticholinergic or diuretic-induced symptoms (she is on neither).
- **Surgical candidacy: she is a reasonable candidate and is genuinely interested, but proceeding today would be premature.** Favourable: surgically naive pelvis with no mesh, no chronic cough, never smoked, no anticoagulant, independent, motivated, and clear about her goals. Unfavourable or to be optimised first: BMI 32.1, HbA1c 7.3%, untreated constipation, untreated atrophy, an active erosion, grade 1 pelvic floor strength, and **no urodynamic study**. **Since she needs a concurrent continence procedure, urodynamics before committing is important** — particularly to exclude impaired detrusor contractility, which would substantially raise her risk of post-operative retention after a sling.
- **Because she is not sexually active and states that sexual function is not a treatment goal, her options are wider than usual** — including colpocleisis, an obliterative procedure with the highest success and lowest morbidity in older women who do not desire vaginal intercourse. Offering it is appropriate; it must be presented honestly as irreversible for penetrative intercourse.
- **No red flags requiring urgent action.** No fever, no retention, no gross hematuria, no incarcerated prolapse, no fresh bleeding, no neurologic deficit, and no suspicious mass. **The right sequence is: heal the erosion, start vaginal estrogen, refer for pelvic floor physical therapy, treat the constipation properly, cut the caffeine and stop restricting fluid, obtain urodynamics, refit the pessary — and then make the surgical decision from an optimised baseline with complete information.**

P PLAN

13 MANAGEMENT BY PROBLEM

- **Vaginal estrogen — started today, and the single highest-yield intervention in this plan.** Estradiol vaginal cream 0.5 g nightly for 2 weeks, then twice weekly indefinitely (alternatively an estradiol vaginal insert; cream chosen so she can apply it directly to the erosion site). It addresses three problems at once: healing this erosion and preventing the next, reducing recurrent urinary tract infections through restoration of the vaginal microbiome, and improving tissue quality for pessary tolerance and surgical durability. Counselled explicitly that systemic absorption from low-dose vaginal preparations is minimal, that she has no breast or endometrial cancer history, and that vaginal bleeding on treatment must be reported. **Twenty years without it is the most correctable gap in her care.**
- **Pessary erosion — device out, tissue rested, then refitted.** Pessary removed today and **held out for 3 weeks** to allow the erosion to heal on estrogen; she was warned her bulge will return in the interim and was given a support garment and advice to avoid heavy lifting. Refit at the 3-week visit, likely to a **Gellhorn or ring with knob** to change the pressure distribution, or the same size 4 ring if the tissue has improved substantially. **If the erosion has not healed by 4–6 weeks of estrogen with the pessary out, biopsy is mandatory** — stated to her plainly.
- **Pessary self-management — retaught and now achievable.** The erosion happened because the device stayed in for 14 weeks untouched. Retaught with a mirror, in a modified position accommodating her knee arthritis, with a **removal hook provided**; she successfully removed and reinserted a practice device twice today, which she had

never managed before. New schedule: **remove weekly overnight, wash with soap and water, reinsert in the morning** — giving the tissue a regular rest. Written illustrated instructions provided. Clinic checks every 3 months while self-managing.

- **Pelvic floor physical therapy — referral placed today, and overdue by decades.** Modified Oxford grade 1 of 5 with incorrect gluteal and abdominal recruitment; she has never had formal instruction. Referral for a 12-week supervised programme covering motor learning with biofeedback, progressive strengthening, the "knack" (pre-contraction before cough or lift — directly relevant to lifting her grandson), bladder training with timed voiding and urgency suppression for the key-in-door trigger, and defecation dynamics with proper toileting posture. **This is first-line, evidence-based, zero-risk therapy for both her stress incontinence and her prolapse, and it must be given a genuine trial before surgery is decided.**
- **Behavioural and fluid modification — specific and quantified. Reduce caffeine from five drinks daily to one** by tapering one drink weekly to avoid headache; eliminate the two diet colas (caffeine plus artificial sweetener, both bladder irritants). **Stop restricting fluid — increase to 1.8–2 L daily**, weighted toward the morning and afternoon with little after 7 pm; the explanation that restriction concentrates irritative urine and worsens both leakage and constipation was persuasive to her. Timed voiding every 2.5–3 hours with gradual interval extension. Urgency-suppression technique taught. Leg elevation in the late afternoon to mobilise dependent edema before bedtime, addressing the nocturia.
- **Recurrent urinary tract infections — prevention rather than more antibiotics.** Vaginal estrogen is the primary intervention (as above). Increased fluid intake. **Explicitly counselled that asymptomatic bacteriuria will not be treated**, and that a culture is only sent when she has symptoms — treating asymptomatic bacteriuria in older women causes resistance and harm without benefit. When symptomatic, **culture first, then targeted therapy avoiding penicillins given her documented allergy**; nitrofurantoin remains suitable with her normal renal function. No continuous prophylaxis at this stage — estrogen alone frequently suffices, and prophylaxis would be revisited only if infections continue on adequate estrogen. Diabetes optimisation flagged to primary care (HbA1c 7.3%).
- **Constipation — a proper regimen, replacing irregular docusate.** This matters beyond comfort: chronic straining caused her prolapse and would undermine any repair. **Polyethylene glycol 17 g daily (scheduled, not as needed)**, titrated to a soft Bristol type 4 stool. Fiber increased to 25–30 g daily through gradual introduction of legumes, fruit, and whole grains, with the fluid increase making it effective. Psyllium if dietary fiber falls short. Toileting posture with a footstool to achieve hip flexion and a relaxed pelvic floor, taught today. Bowel diary. Physiotherapy will address defecation dynamics. Docusate discontinued as ineffective as monotherapy. **Colonoscopy is up to date (2019, normal, next due 2029) and today's occult blood was negative**, so no GI referral now — reconsidered only if constipation persists after an adequate trial.
- **Urodynamic study — ordered today, before any surgical commitment.** Indicated because she has mixed symptoms with a demonstrable occult stress component and is contemplating surgery. Purposes explained to her: quantify the stress component, measure valsalva leak point pressure, detect detrusor overactivity that might need separate treatment, and **exclude impaired detrusor contractility, which would substantially raise her risk of urinary retention after a sling**. To be performed with the prolapse reduced. Cystoscopy not ordered — no hematuria, no bladder pain, no indication.
- **Surgical options — presented in full, decision deliberately deferred.** Discussed with the explicit principle that **because her stress incontinence is unmasked by reduction, any prolapse repair must include a concurrent continence procedure or she will end up worse than she is now**. Options laid out: (1) **vaginal hysterectomy with native-tissue anterior and posterior repair and apical suspension (uterosacral or sacrospinous), plus a midurethral sling** — comprehensive, single anaesthetic, preserves vaginal function; (2) **sacrocolpopexy after hysterectomy** — the most durable apical repair but a larger abdominal procedure at 71 with obesity and diabetes; (3) **colpocleisis with a concurrent sling** — highest success and lowest morbidity, well suited to her since she is not sexually active and states sexual function is not a goal, presented honestly as **irreversible for penetrative intercourse**; (4) **continued pessary with optimised care** — entirely legitimate and her current path. Risks reviewed for each: recurrence, mesh complications (sling only, native tissue otherwise), de novo urgency, post-operative retention, dyspareunia, injury to bladder, ureter, or bowel, VTE, and anaesthetic risk. **She was neither pushed toward nor away from surgery; she will decide after the erosion heals, physiotherapy has been trialled, and urodynamics are back.**

- **Pre-operative optimisation, begun now regardless of her eventual choice.** Weight: 5–10% loss discussed supportively and without moralising, as it independently improves both incontinence and prolapse — nutrition referral placed and accepted. **Glycaemic control: HbA1c 7.3% flagged to Dr. Sowande with a target below 7% before any elective surgery**, given wound-healing and infection implications. Constipation, atrophy, and pelvic floor strength all being addressed as above. No smoking (never smoked) and no anticoagulant — both favourable. Anaesthesia assessment when and if a surgical date is set.
- **Vulvar skin care.** Irritant dermatitis from pad occlusion: barrier ointment (zinc oxide or petrolatum) after each change, breathable cotton underwear, avoidance of scented wipes and soaps, and more frequent pad changes. Reassess at the 3-week visit — and note that improving her continence is the definitive treatment for her skin.
- **Contingency for the discharge — stated unambiguously.** The brown discharge is fully explained by a visible erosion with a benign-appearing base, and no endometrial sampling is indicated today. **However, if discharge persists after the erosion heals, or if any fresh vaginal bleeding occurs at any point, transvaginal ultrasound with endometrial assessment and biopsy will be mandatory** — she has a uterus, is 71, is 20 years postmenopausal, and is about to start vaginal estrogen, so postmenopausal bleeding can never be attributed to the pessary without investigation.
- **Coordination, education, and safety.** Referrals placed: pelvic floor physical therapy, urodynamics, nutrition. Coordination note sent today to Dr. Sowande covering the erosion and its management, the vaginal estrogen rationale for both erosion and infection prevention, the HbA1c target, and the constipation regimen. Written materials provided: illustrated pessary self-care, pelvic floor exercise instructions, a bladder and bowel diary, caffeine taper schedule, and a surgical options summary to read at home with her daughter. Teach-back confirmed on pessary handling, estrogen application, and the polyethylene glycol regimen. **Instructed to contact the clinic for increasing or malodorous discharge, any fresh vaginal bleeding, pelvic pain, fever, or inability to pass urine; and to seek emergency care for complete inability to urinate, fever with flank pain and vomiting, or heavy vaginal bleeding.** Direct clinic and after-hours numbers given, and she was reassured that her decision to raise the leakage and the discharge was exactly right.

F FOLLOW-UP

14 REASSESSMENT PLAN

Follow-up

Return in 3 weeks (09/10/2026) for erosion review with speculum inspection, response to vaginal estrogen, and **pessary refitting** (Gellhorn or ring with knob, or the same size 4 ring if tissue quality has improved), with self-management technique reconfirmed. **Biopsy of the erosion if it has not healed after 4–6 weeks of estrogen with the pessary out.** Urodynamic study within 4–6 weeks, performed with the prolapse reduced. Pelvic floor physical therapy starting within 2–3 weeks for a 12-week programme, with progress reviewed at completion. Bladder and bowel diary repeated before the next full visit. **Comprehensive reassessment in 3 months** (11/2026): repeat PFDI-20, PFIQ-7, ICIQ-SF, and UDI-6 against today's baselines, POP-Q with the pessary out, post-void residual, physiotherapy outcome, constipation response, and urodynamic results — **at which point the surgical decision will be made from an optimised baseline with complete information**. Urine culture only if symptomatic; asymptomatic bacteriuria will not be treated. HbA1c and weight followed by primary care. **Contact sooner for increasing or malodorous discharge, any fresh vaginal bleeding, pelvic pain, fever, or inability to pass urine.**

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

58 minutes

COUNSELING / EDUCATION TIME

21 minutes — surgical options, unmasked stress incontinence mechanism, vaginal estrogen rationale, UTI stewardship

PELVIC FLOOR COUNSELING TIME

9 minutes — correct levator isolation, the “knack”, physiotherapy expectations, toileting posture

PESSARY MANAGEMENT TIME

16 minutes — removal, wall inspection, cleaning, self-management retraining with practice device and hook

PROCEDURE TIME

14 minutes — pessary removal with inspection, POP-Q with reduction and cough stress testing, post-void residual, rectovaginal examination

CARE COORDINATION TIME

6 minutes — physiotherapy, urodynamics, nutrition referrals and the primary care note

RECORDS REVIEW TIME

8 minutes — five prior urine cultures, 02/2026 POP-Q comparison, 1981 obstetric record, bladder diary

E/M LEVEL

99214 — established patient, moderate-to-high complexity MDM (multi-problem management with a new prescription and surgical decision-making in progress)

PESSARY FITTING / MANAGEMENT CODE(S)

57160 — fitting and insertion of pessary or other intravaginal support device. Billed for the removal, inspection, and management encounter; no device reinserted today — refitting to be billed at the 3-week visit

URODYNAMIC TESTING CODE(S)

None performed today. Ordered: 51728 complex cystometrogram with voiding pressure studies; 51741 complex uroflowmetry

CYSTOSCOPY CODE

Not applicable — not indicated (no hematuria, no bladder pain, no suspicion of intravesical pathology)

CATHETERIZATION / POST-VOID RESIDUAL CODE(S)

51798 — measurement of post-voiding residual urine by ultrasound (non-imaging). No catheterisation performed

PROCEDURE CODE(S)

81002 — urinalysis without microscopy, non-automated. POP-Q staging, cough stress test, and rectovaginal examination included in the E/M and not separately reportable

BASIS FOR BILLING

Time-based and moderate-to-high MDM with a separately identifiable device-management service (modifier 25 on the E/M)

PRIMARY DIAGNOSIS

N81.11 — Cystocele, midline (stage III anterior vaginal wall prolapse)

SECONDARY DIAGNOSES

N81.2 Incomplete uterovaginal prolapse; N81.6 Rectocele; N39.3 Stress incontinence, female; N39.46 Mixed incontinence; N30.20 Other chronic cystitis without haematuria / recurrent UTI (N39.0 urinary tract infection, site not specified); N95.2 Postmenopausal atrophic vaginitis; T83.79XA Erosion of implanted vaginal mesh or other prosthetic materials — pessary-related vaginal erosion, initial encounter; Z97.5 Presence of contraceptive/intravaginal device; K59.00 Constipation, unspecified; N89.8 Other specified noninflammatory disorders of vagina (vaginal discharge); L24.9 Irritant contact dermatitis; E11.9 Type 2 diabetes mellitus; E66.9 Obesity; M81.0 Age-related osteoporosis; Z87.898 Personal history of obstetric perineal laceration

SO

PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Gerald T. Okpara, MD	MD — Female Pelvic Medicine & Reconstructive Surgery	Urogynecology / Female Pelvic Medicine and Reconstructive Surgery	08/20/2026	10:48

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