Pessary Care Instructions for Healthcare Providers

Pessary Facts

- Pessaries can be used on a long-term basis as an alternative to surgery.
- A variety of healthcare providers can fit pessaries, including trained physicians, nurses, and physiotherapists.
- Pessaries can be used for women of all ages.
- Pessaries can be used for women who have or have not had a hysterectomy.
- 70 – 90% of patients can be successfully fitted with a pessary.
- Pessaries can be used during menstruation. Patients may notice a change in colour of their pessary.
- Pessaries can be used with an IUD.
- Complications related to pessaries are rare (88.5% of patients have no complications).
- Locally applied, topical vaginal estrogen does not increase the risk of breast cancer, heart disease, or stroke.

Pessary Care

- When possible, patients can self-care for their pessary (remove and insert on their own). Self-care may be done as often as daily.
- If self-care is not possible, pessary follow-up care should be provided by a trained clinician every 3 to 6 months depending on the pessary and the advice of the care provider. Patients may choose to clean their pessary more frequently.
- If pessary self-care is being done by a patient, ensure that they are aware of the need for yearly vaginal examinations with a speculum and have a plan if any issues arise (foul discharge, bleeding, pain, dislodgement, etc.).
- On average, most pessaries will last for 5 to 7 years before they need to be replaced. However, inspecting the device for cracks, tears, and loss of shape would necessitate earlier replacement.

If patient has a pessary in place, these are recommended instructions for ongoing care and assessment:

Pain

- Pain could be due to the following reasons:
    - Pessary size is too large (causing pressure) or too small (moving and dislodgement).
    - An erosion.
    - Significant weight gain or loss, or changes in the prolapse. A different size of pessary may be needed if patient has lost or gained weight or if their prolapse has changed.

Bleeding

- Bleeding may be caused from pessary irritation on the vaginal tissues, causing an abrasion, erosion, or persistent ulcer. Bleeding may also be due to an infection.
- If an obvious source of bleeding cannot be visualized, patient should be assessed by a gynecologist for consideration of a pelvic ultrasound and endometrial assessment to rule out malignancy.
- Any nonhealing ulcer should be assessed by a gynecologist for consideration of a biopsy to rule out malignancy.

Vaginal discharge

- An increase in vaginal discharge is expected as the body's natural, healthy response to a foreign object.
- Abnormal discharge is bloody, brown, green, and has a foul odour.
- If abnormal vaginal discharge is present, an infection and vaginal abrasion/erosion/ulcer need to be ruled out. If infection has been ruled out, it is recommended that the patient be prescribed local estrogen.

Local Estrogen

- Long-term use of local estrogen is an important consideration for post-menopausal women to avoid formation of an erosion.
    - Premarin 0.5g PV daily for two weeks then twice per week.
        - Cream with applicator
        - Cost: $25 per 14g tube ($1.78/week)
    - Estragyn 0.5g PV daily for two weeks then twice per week.
        - Cream with applicator
        - Cost: $68 per 45g tube ($1.51/week)
    - Vagifem 10mcg PV daily for two weeks then twice per week.
        - Tablet with applicator
        - Cost: $64 per 18 tablets ($7.11/week)
    - Estring 2mg PV for 3 months.
        - Used continuously and replaced every 3 months
        - Cost: $129 per device ($10.75/week)
- There are very few contraindications to vaginal estrogen. If a patient is unable to use vaginal estrogen, they can consider long-term use of over-the-counter non-hormonal moisturizer or natural lubricant such as coconut oil. Vaginal lubricants are only recommended for insertion and removal of the pessary.

Obstructive Voiding or Defecation Issues

- This may be from a pessary that is too large or displaced, in which case an assessment by a healthcare provider is required.
- If a pessary becomes displaced during a bowel movement, it can be pushed inwards after a bowel movement. Alternatively, a finger can be held at the vaginal opening to support the pessary to prevent it from falling out.
- If a patient has a urinary tract infection (UTI), consider measuring a post-void residual to determine whether obstructive voiding is present.

EXAMINATION AND ASSESSMENT of the patient with a pessary in place:

1. ASK patient:

- Is the pessary comfortable? Has it remained in place?
- Is the pessary adequately managing symptoms? Is the patient satisfied with the pessary?
- How often is the patient removing and reinserting pessary? Is there any difficulty with removal and reinsertion?
- Is patient having any issues with pessary? Pain? Bleeding? Abnormal vaginal discharge? Difficulty emptying bladder or bowels?
- Is patient using vaginal estrogen? How often?

2. Complete EXAMINATION with the pessary in place:

- Inspect for correct placement and optimal reduction of prolapse.
- Insert finger into vagina and assess pessary fit.

3. REMOVE pessary:

- Examine external perineal tissues for health and note any odour.
- Spread labia and perform Valsalva by asking patient to bear down. Note if pessary descends and can be seen at the introitus.
- Hook finger under the edge of pessary or grasp with thumb and gently withdraw pessary along the posterior wall, avoiding the anterior wall as much as possible.
- Special considerations:
  - If there is any difficulty grasping the pessary, consider using a ring forceps to grasp the pessary and bring it down closer to introitus to enable it to be removed.
  - For any space occupying pessary (Gellhorn or cube), it may be easier to use a tenaculum, sponge, or Kelly forceps applied to the stem to provide gentle downward traction on the pessary while using the other hand to release the suction. Pessary is then brought down to introitus and removed.

4. EXAMINE pessary:

- Examine general condition of the pessary. Note any blood, staining, discharge, cracks, pliability, and foul odour.
- Wash pessary with soap and water.

5. EXAMINE vagina:

- Perform a speculum examination. Observe vaginal tissues for any areas of irritation, redness (pressure points), bleeding.
- If an erosion is present:
  - If there are sites of obvious bleeding, apply silver nitrate to cauterize bleeding and potentially enhance healing.
  - If there are erosions, consider leaving pessary out for 2 to 4 weeks (dependent on severity) and ask patient to use vaginal estrogen daily for up to 2 weeks.
  - If examination reveals a site with a deep erosion, carefully assess it digitally to ensure that there is no fistula formation.
  - If patient cannot cope without pessary in place, follow the same steps above with pessary in place and reassess in 2 weeks.
  - Follow-up in 2 weeks with speculum examination.
    - If there is no erosion, then reinsert pessary and decrease local estrogen use to twice per week.
    - If erosion is present, keep pessary out for another 2 weeks, use daily local estrogen cream, and follow-up in 2 weeks.
- If there is foul smelling vaginal discharge:
  - Keep pessary out.
  - Use Replens, oral or vaginal metronidazole, or vaginal clindamycin cream.
  - Follow-up in 7 days.

6. REINSERT pessary:

- Fold (if circular) or compress (if cube) pessary.
- Apply lubricant to the leading edge of the pessary and the introitus.
  - Vaginal estrogen cream may also be applied to the pessary and treated like a “dose” of medication.
- Using non-dominant hand to spread patient’s labia, gently insert the pessary putting pressure on the posterior vaginal wall and sliding it inwards and downwards towards the sacrum.
  - Circular pessary is inserted “like a taco,” with circular edge up.
  - For Gellhorn pessary, the stem is bent towards the circular base of the pessary and pessary is inserted while avoiding the anterior vaginal wall.

- Check position of pessary. The anterior edge should be behind the pubic symphysis. The posterior edge should be as far back as possible. Pessary should never be wedged in.
- Ask patient to perform Valsalva and observe whether pessary stays in place or falls out. Ensure that patient cannot feel the pessary in place.

7. FOLLOW-UP

- Ensure that patient is aware of recommendations for ongoing pessary care, such as use of vaginal estrogen or moisturizers, frequency of self-removal of pessary (if applicable), and the next recommended follow-up appointment time.
- Ensure that patient is aware of complications, including pain, bleeding, abnormal vaginal discharge, voiding and defecatory issues, and whom to contact if any complications arise.
- Encourage and provide instructions regarding self-care whenever it is possible.

References

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