POP for PCPs

Pessaries for Pelvic Organ Prolapse in Primary Care

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Learning Objectives

1. Describe how to assess pelvic organ prolapse
2. Recognize contributing factors that should be addressed in primary care
3. Describe the role for pessaries in managing pelvic organ prolapse
4. Develop increased comfort and skill managing post placement care for patients with pessaries.

Think ? pelvic organ prolapse…

"something coming down"

Urinary or bowel dysfunction

Vaginal or pelvic pressure

Sexual difficulties

"Descent of pelvic organs such as the uterus, bladder, or bowel protruding into the vagina because of pelvic floor muscle weakness"

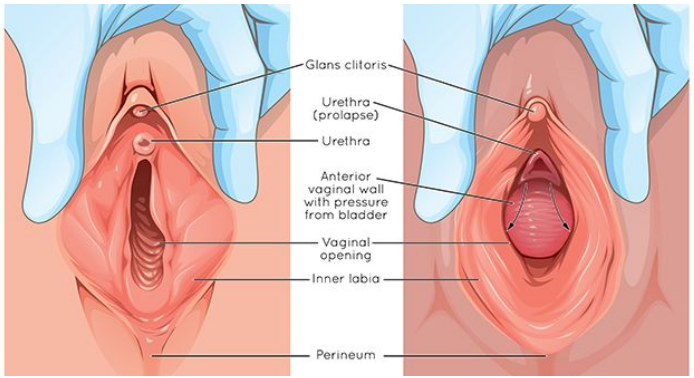
Prevalence & Risk Factors

- 40% of women >40yo.
- **Address the modifiable Risk Factors!!!**

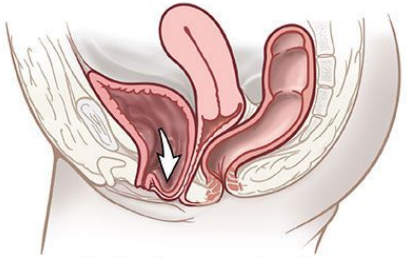
Category	*Risk factors*
Ethnicity	Hispanic adults[2]
General	Advancing age, increasing body mass index, menopause,[5,6] low socioeconomic status[7]
Increased intra-abdominal pressure	Chronic cough caused by smoking, chronic lung disease,[8] straining with chronic constipation or repeated heavy lifting[7,9]
Obstetric	Current pregnancy, previous prolonged labor, instrumental delivery, episiotomy,[10] increasing parity, weight of babies[5] *
Previous surgery	Hysterectomy,[11] previous prolapse surgery

Evaluation

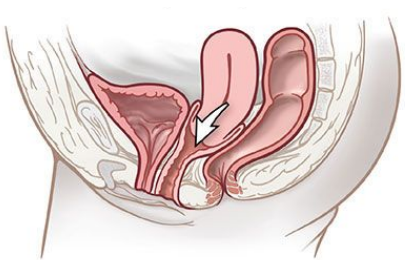
- Supine or HOB @ 45deg +/- standing
- Observe with & without Valsalva
- Speculum Exam
  - Slowly remove during valsalva
  - Disassemble & use only the posterior blade to assess anterior & posterior walls independently
  - Bimanual examination - estimation of vaginal hiatus and fornix - pubic bone diameter



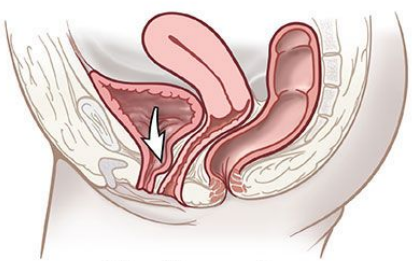
Terminology



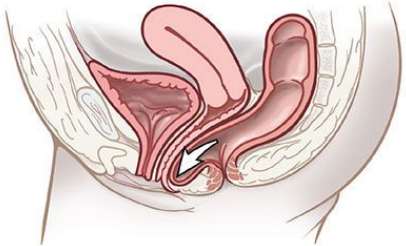
Anterior vaginal wall prolapse



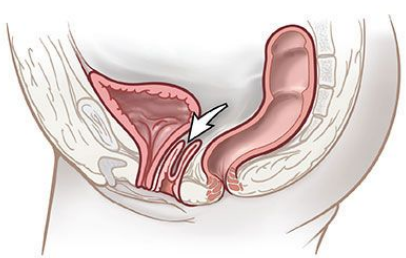
Uterine prolapse



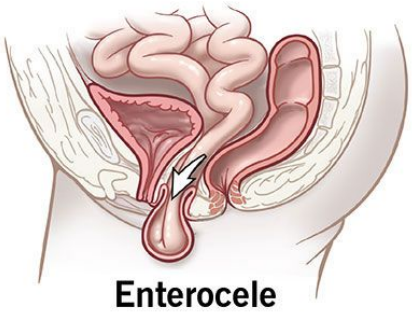
Urethrocele



Posterior vaginal wall prolapse



Vaginal vault prolapse

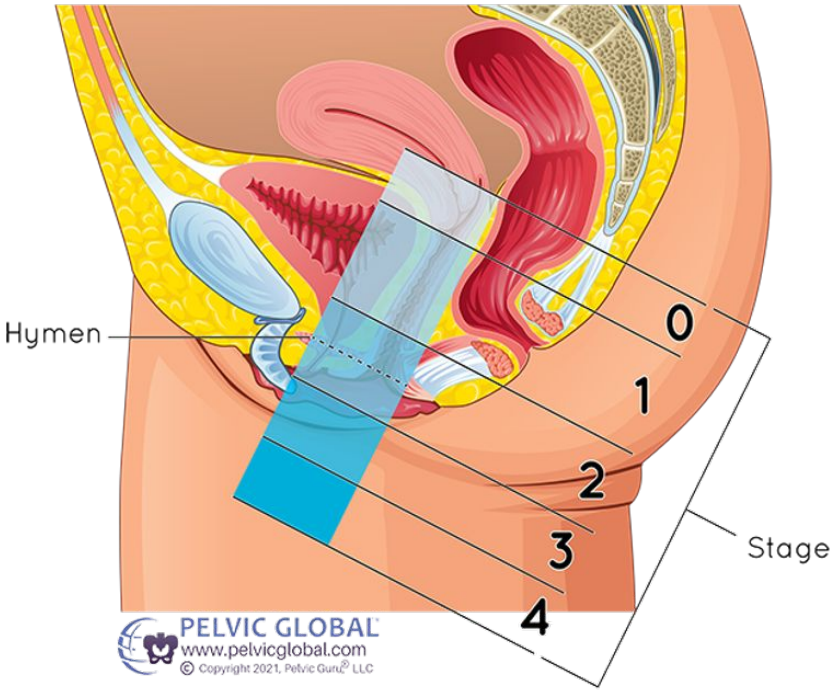


Enterocele

Staging - Braden-Walker > POP-Q:

measure most distal during straining

Baden-Walker system	
Grade	*Description*
0	Normal position for each respective site, no prolapse
1	Descent halfway to the hymen
2	Descent to the hymen
3	Descent halfway past the hymen
4	Maximal possible descent for each site



Treatment of POP

- Pelvic floor muscle training (PFMT) is recommended as conservative intervention either alone or in combination with pessary use.
- Pessaries are 1st line, non-surgical management
  - Cystocele/Anterior Wall Prolapse
  - Uterine/Vaginal Vault Prolapse
  - Rectocele/Posterior Wall Prolapse
  - Stress Urinary Incontinence
  - Preoperative preparation
- Surgery

vaginal pessary

surgery

Best Candidates for Local Pessary Fitting Referral

- Consider mobility
- Working with PFMT
- Stage I-II. Can consider with Stage III/IV, but lower success rates - be sure patients are aware.
- Consider pretreatment with vaginal estrogen (*esp w/ Atrophy, narrowed tissues)
- Cost ~$70 each (can take more than one to find right fit).
- Follow up can be adopted (both by patient and provider!).

Pessary Fitting

- Trial and error
- Digital measurements
- Assess comfort, ability to void with device in place, assess risk of expulsion (squat and valsalva), and reduction in prolapse symptoms.

MILEX Ring Folding Pessaries

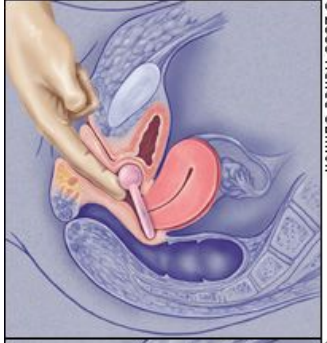
Pessary Treatment Success

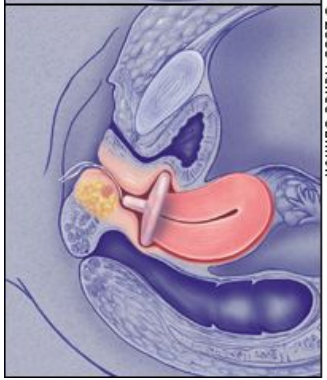
Predictors of LOWER success:

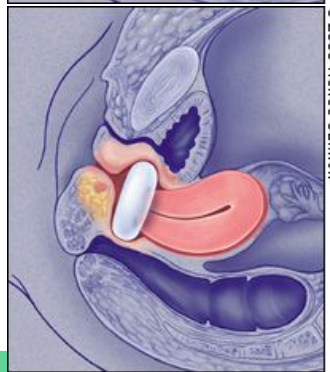
- prior POP surgery
- Hysterectomy
- short vaginal length
- wide genital hiatus
- posterior compartment involvement
- more severe (grade III/IV) prolapse

Predictors of HIGHER success:

- older age
- ability for self- or family-supported-management







Pessary Types	Good for	Common Sizes	Ease of insertion & removal
Ring pessaries (with or without support, with or without incontinence knob)	ease of insertion and removal, making them suitable for sexually active women and those with mild to moderate prolapse	2-5	Easy
Gellhorn pessaries	for more severe prolapse, especially in women with younger age, larger hiatal circumference, history of hysterectomy, or wide vaginal introitus	2.25-3.75”	Difficult
Donut pessaries	wide vaginal introitus or when other types fail	2.5-3’	Medium

Maintenance & Ongoing Care

- Pessary Maintenance
  - Removal & cleaning (hand soap & water)
  - Vaginal inspection for erosions or infection.
  - Frequency q3-4mo, longer for self-managing patients
  - Vaginal estrogen compliance/introduction - ⬇erosions and discharge
  - Review & manage modifiable risk factors
  - Education on self-care
- Self-Management
  - Education on insertion & removal with annual review with provider

Troubleshooting

- Discomfort - reassess fit, r/o erosions, consider adding vaginal estrogen
- Vaginal discharge - r/o infection, consider vaginal estrogen, or weak vinegar solution (10%)
- Bleeding - r/o erosions, r/a fit, consider vaginal estrogen
- Fistula/impaction (rare) - generally a result of neglect in care ➜ Gyne

Evidence for Pessaries

- NNT=3 when added to PFMT
- NNH=27 for abnormal vaginal bleeding.
- High initial fitting success (41-96%) with symptom resolution/significant improvement:
  - Vaginal bulge & pressure >90%
  - Obstructive voiding 40-97%
  - Urinary urgency 38% & urge incontinence 29-77%; stress incontinence 9-45%
- Long-term adherence varies, ~24-49% discontinue at 12-24mo d/t discharge, discomfort, erosions, expulsion

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QUESTION Is pessary therapy noninferior to surgery in women with symptomatic pelvic organ prolapse?

CONCLUSION Among patients with symptomatic pelvic organ prolapse, an initial strategy of pessary therapy, compared with surgery, did not meet criteria for noninferiority with regard to patient-reported improvement at 24 months.

POPULATION

440 Women

Adults with stage 2 or greater pelvic organ prolapse and moderate to severe prolapse symptoms

Mean age: **64.7** years

LOCATIONS

21
Hospitals
in the Netherlands

INTERVENTION

440 Patients randomized
335 Patients analyzed

173
Pessary therapy
Patient fitted with a supportive or occlusive pessary device

162
Surgery
Surgical procedure based on prolapse type and shared decision with patient

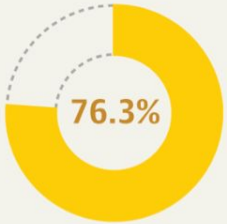
PRIMARY OUTCOME

Subjective patient-reported improvement of symptoms at 24 months as measured using the Patient Global Impression of Improvement (PGI-I) scale

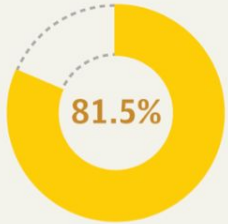
FINDINGS

Reported improvement of symptoms at 24 months

Pessary therapy
132 of 173 patients



Surgery
132 of 162 patients



Results did not meet criteria for noninferiority:

Between-group risk difference, −6.1%
1-sided 95% CI, −12.7 to ∞
P value for noninferiority, .16

van der Vaart LR, Vollebregt A, Milani AL, et al. Effect of pessary vs surgery on patient-reported improvement in patients with symptomatic pelvic organ prolapse: a randomized clinical trial. *JAMA*. Published December 20, 2022. doi:10.1001/jama.2022.22385

Take Home Points

- POP is a common problem in Primary care (40% > 40y)
- Remember: PFMT, managing modifiable risk factors, and vaginal estrogen
- Local referral: mobility, lower grades, ability for follow up
- When problems arise, think estrogen and pessary size

References

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