# Pessary insertion

*Choosing appropriate patients*

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Pessaries have been around in one form or another since biblical times, and currently there are many different kinds of pessaries to treat the various types of pelvic descent. The term pelvic organ prolapse refers to any pelvic structure that protrudes into the vagina (cystocele, rectocele, enterocele). Patients with prolapse who are asymptomatic do not require treatment. For a patient who has symptoms, a pessary can be an excellent alternative to surgery or can help to control symptoms until surgery is performed.[1]

Counseling patients about the option of using pessaries, fitting them in your office, and maintaining their care can become part of your practice. Eighty percent of pelvic prolapse (grades 1 and 2, defined as descending above the hymen) can be treated with ring-shaped pessaries. This article will discuss how to evaluate patients and insert this type of pessary. (For an algorithm on the diagnosis and management of pelvic organ prolapse, see **page 485**.)

## Choosing the right patient

Pessaries are not for everyone. One must consider both pelvic and patient factors.

***Pelvic factors.*** A pessary will work best if the uterus is present. Ring-shaped pessaries will help treat grade 1 and 2 cystoceles, urethroceles, uterine prolapse, and stress incontinence. To evaluate a patient, place her in the lithotomy position and examine her at rest. Next observe as she bears down slowly with the Valsalva maneuver (not by coughing, as this is too brief). Insert a lubricated speculum, rotate it 90°, and gently open it so that the anterior and posterior walls are visible, both at rest and with the Valsalva maneuver. Another technique is to take apart the blades of the bivalve speculum and insert only the long-handled blade. By gently pressing the blade against the anterior or posterior wall and asking the patient to perform a Valsalva maneuver, one can see prolapse in the opposite compartment.[2] If the prolapse is grade 1 or 2, a ring pessary is a good treatment.

***Patient factors.*** A pessary requires regular care by the patient or a health care provider. The patient has to be comfortable with a foreign object in her vagina and be willing to remove and clean it on an ongoing basis, or have a health care provider do so. The patient or an assistant must be able to insert vaginal applicators regularly. Postmenopausal women require 2 to 3 months of topical estrogen applied 2 or 3 times weekly before a pessary is fitted[3] in order to be fitted comfortably. Latex allergy is not a contraindication, as most pessaries are silicone. Risks of wearing a pessary include vaginal infection, erosions, discharge, odour, pain, bleeding, failure to reduce the prolapse, and expulsion. In a Cochrane review there was little evidence and no consensus on the indications, choice of device, or follow-up for pessaries.[4]

## Fitting a pessary

Materials include a set of fitting rings, gloves (which do not have to be sterile), lubricant, and an autoclave.

Once a patient has decided to try a pessary, have her return on a separate visit for fitting. If her menses have ended, the return visit should occur after estrogen therapy to lubricate the vagina. Pessaries are fitted by trial and error. You will need to order from the manufacturer (**Table 1**) a set of fitting rings, which are sterilized between patients. The visit includes fitting the pessary, having the patient try it temporarily, rechecking the fitting, and ordering the device.

**Table 1. Pessary manufacturers**

| MANUFACTURER | TELEPHONE | WEBSITE |
|---|---|---|
| Milex (Cooper Surgical) | 800 243-2974 | www.coopersurgical.com |
| Mentor | 800 668-6069 | www.mentorcorp.com |
| Superior | 800 268-7944 | www.superiormedical.com |

Begin by inserting your middle finger behind the cervix in the posterior fornix and placing your index finger against the pubic notch. The distance between your 2 fingers is used as a starting point in pessary sizing. Withdraw your fingers and choose the fitting ring whose diameter best approximates this distance. Fold the fitting ring in half, lightly lubricate the entering end, and insert it so that part of the ring is behind the cervix and the opposite side is behind the pubic notch (**Figure 1**). This is similar to fitting a diaphragm, aiming for the largest size that fits comfortably. Sweep your finger around the perimeter of the ring to check for pressure points. If the ring does not fit properly, try a smaller or larger size. The average pessary size is 4 or 5, the range being from 2 to 7. The patient should then spend about an hour walking around and trying to void.[3] When she returns, remove the fitting ring and select the appropriate pessary.

A cystocele is treated with a ring with support (filled-in centre), uterine prolapse is treated with a ring without

support (hollow), and stress incontinence is treated with a ring with a knob. Various elements can be combined into one pessary if necessary (eg, a woman with stress incontinence and cystocele would benefit most from a ring with support and a knob, as in **Figure 2**).

**Figure 1. Fitting ring insertion:** *Part of ring should settle behind the cervix and the opposite side behind the pubic notch.*

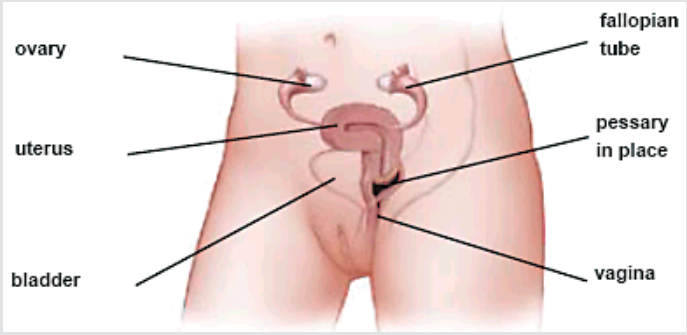


**Figure 2. Various shapes address particular problems:** *This ring with central support and a knob might be used for a woman with stress incontinence and cystocele.*

Most health care practitioners will have to order the pessary directly from the manufacturer (**Table 1**). The cost of a pessary including delivery is approximately $90 and is covered by most insurance plans. Usually a pessary lasts for about 5 years.

After the pessary arrives, the patient returns for insertion and teaching. The pessary with support folds along one axis only. It has 2 small and 2 large holes; when folded, the 2 small holes touch each other. Once inserted, the provider should rotate the pessary 90° so that one small hole is anterior (and the other small hole is posterior) to decrease risk of expulsion. For removal the pessary should be rotated back 90° to facilitate bending.

Teach patients how to remove and insert pessaries. If a patient is uncomfortable removing a pessary, a long piece of dental floss can be tied to the pessary so that she can pull it out if necessary. All patients should be checked within a week after new pessary insertion.

## Maintenance

Pessaries can be removed daily, weekly, or monthly, at patients' discretion, for washing with regular soap and water. Ring pessaries can be removed or left in place for intercourse. Patients can also insert their pessaries as needed (eg, to address stress incontinence with exercise). If patients are unable to care for the devices on their own, they will require health care providers to remove, wash, and re-insert them every 3 to 6 months. To prevent infections and odours, an acidifier (usually supplied with the pessary) or estrogen must be applied vaginally 2 or 3 times weekly. Oral or transdermal estrogen or an estradiol-17 ring (placed behind the pessary) are also options.[3]

All patients wearing pessaries should be examined by health care professionals every 3 to 6 months to check for vaginal erosions or ulcers. If lesions are found, pessaries should be removed until the lesions have healed, and affected areas should be treated with topical estrogen.[1]

## Personal perspective

The idea of fitting a pessary can be daunting, as it was for us. We began fitting pessaries because of a perceived need by patients, a lack of colleagues with these skills, and involvement in an educational initiative for benign uterine conditions. The first pessary fitted was a learning experience, but the procedure quickly became easier. Offering this option has opened up discussion and increased awareness of pelvic organ prolapse in our practices.

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### References

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We encourage readers to share some of their practice experience: the neat little tricks that solve difficult clinical situations. Tips can be sent by mail to **Dr Diane Kelsall**, Editor, *Canadian Family Physician*, 2630 Skymark Ave, Mississauga, ON L4W 5A4; by fax 905 629-0893; or submit on-line at **http://mc.manuscriptcentral.com/cfp.**