PRIMARY CARE WOMEN’S HEALTH FORUM CONSERVATIVE MANAGEMENT OF PROLAPSE

Competency Framework For Primary Care
The PCWHF was formed as a focus for all interested practitioners within the multi-disciplinary team on women’s health issues and with a primary aim of continuous sharing of best practice in relation to national, regional and local developments in women’s health issues.

The PCWHF is a community interest company with over 5000 members from Primary Care. It is nationally recognised and widely consulted. More information can be found at [http://www.pcwhf.co.uk/](http://www.pcwhf.co.uk/)

It was with that focus in mind that forum members came together to write the Primary Care Women’s Health Forum competency framework for conservative management of prolapse.

It is recognised that some clinicians will both fit and check pessaries, while others will provide follow up care. The principles involved apply to both levels of care and only the practical competencies will differ.

**For Commissioners:**
- This follows expert guidance and is a practical commissioning framework for local delivery of services.

**For Clinical Leads in Women’s health:**
- This sets out pragmatic and agreed advice from those working in Primary Care.

**For Practitioners:**
- This sets out best practice guidance that keeps you safe and ensures clinical competency in the deployment of your skills.
- It supports CPD and appraisal requirements.

**For Patients:**
- All women presenting in primary are should expect to receive care in line with best practice for pelvic organ prolapse management.
Introduction

Pelvic organ prolapse is common, affecting up to 50% of parous women\(^1\), with one in five reporting prolapse related symptoms\(^2\). Pelvic organ prolapse is characterised by descent of any of the pelvic organs into the vagina and at times beyond the introitus. Pelvic organ prolapse can cause a significant reduction in quality of life for a woman.

Definition: hernia of one or more pelvic organs (uterus, vaginal apex, bladder, rectum) and its associated vaginal segment.

Types of prolapse:

- Anterior vaginal wall prolapse:
  - Urethrocele: urethral descent
  - Cystocele: bladder descent
  - Cystourethrocele: descent of bladder and urethra
- Posterior vaginal wall prolapse:
  - Rectocele: rectal descent
  - Enterocele: small bowel descent
- Apical vaginal prolapse
  - Uterovaginal: Uterine descent with inversion of the vaginal apex
  - Vault: Post hysterectomy inversion of the vaginal apex

Factors contributing to an increased risk of prolapse:

- Pregnancy & childbirth
- Vaginal delivery
- Ageing
- Menopause
- Obesity, Large Fibroids, Pelvic tumours
- Chronic cough, Straining
- Heavy Lifting
- Genetic conditions e.g. collagen deficiencies
- Previous pelvic surgery
- Spinal cord injuries/neurological conditions e.g. MS, muscular dystrophy.

Grading of prolapse:

- 0: No descent of pelvic structures during straining
- I: The leading edge of prolapse does not descend below 1cm above the hymen
- II: The leading edge of prolapse extends from 1cm above the hymen to 1cm below the hymen
- III: The prolapse extends more than 1cm beyond the hymen but there is not complete vaginal eversion
- IV: The vagina is completely everted

Symptoms of prolapse:

- Often none
- Heaviness, awareness of bulge/ protrusion, dragging sensation
- Requirement to reduce prolapse to void/defecate
- Urinary: poor stream recurrent UTIs, frequency, urgency, stress incontinence
- Bowel: obstructed defecation
- Sexual dysfunction/ discomfort
- Rarely - renal impairment

Management of prolapse:

- Address concurrent medical problems that may contribute.
- Reduce weight where appropriate
- Avoid heavy lifting and adjust lifting techniques
- Manage constipation
- Ensure adequate vaginal oestrogen
- Pelvic floor exercises
- Supportive pessary
- Surgery
Supportive pessaries

A pessary is a device inserted in the vagina to support the walls and related pelvic organs. It offers a low risk management option.

Pessary fitting is an important skill and requires knowledge and competency assessment to ensure identification and counselling of the appropriate patient, correct and safe technique and the understanding and management of complications.

Indications for pessary management

- Symptomatic pelvic organ prolapse
- Patient choice
- As a therapeutic test - can aid pelvic floor assessment and treatment
- For women in whom childbearing is not complete
- For women who are medically unfit for surgery
- While awaiting surgery

Aim of this competency framework

Relevant training is needed to ensure appropriate patient selection, pessary fitting and long-term follow up to minimise the potential for uncommon but potentially serious side-effects of long term pessary use, such as erosion and infection³,4,5.

This competency framework is developed for pessary insertion and subsequent management in primary care. It can be used by clinicians who are checking and changing supportive pessaries in primary care.

Objectives

- To assess and advise regarding management options.
- To improve patient choice and experience by offering pessary management in the community.
- To ensure that standards of care are consistent, and evidence based.
- To develop pathways that deliver quality, cost-effective, streamlined care.

This guideline was correct at the time of going to print and the Primary Care Women’s Health Forum (PCWHF) will undertake annual reviews of this guidance to ensure it remains in line with best practice. The next review is due in April 2019. The guidelines are for use by healthcare professionals only. The guidance has been compiled by the PCWHF and views expressed are of the PCWHF and do not necessarily represent those of individuals or partners. The pathway was adapted with permission from one developed by the Clinical Improvement Group for Gynaecology, Southern Derbyshire CCG. This guideline has had no pharmaceutical sponsorship. Some PCWHF authors have received payment for teaching on the subject. This may be reproduced by HCPs for educational purposes. It cannot be reproduced by anyone else without explicit permission. For further information, please contact: enquiries@pcwhf.co.uk
Urinary incontinence
Follow local female urinary incontinence pathway

Keen on surgical correction

Patient presents with prolapse

Red flags

Pelvic floor exercise programme
Discuss vaginal oestrogen

If patient prefers conservative treatment
- Assess for ring pessary
- Use PVC ring for fitting
- Consider use of silicone ring on review
Discuss option of self management

Review at a month
Reassess every 4-6 months

Failed conservative treatment

Refer routine gynaecology

Examine to assess severity
- Urine analysis
- Identify treatable risk factors
  - Obesity
  - Chronic cough
  - Constipation

2 WW urgent cancer pathway

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Is it appropriate to offer a pessary?

Consider the following:

- Degree of prolapse
- Is the prolapse contributing to urinary or faecal incontinence?
- Size of introitus
- Vaginal shape
- Health of vaginal tissues
- Is she sexually active?
- Dexterity if self-managing insertion and removals

Exclusion criteria

- Active vaginal infection
- Pelvic inflammatory disease
- Undiagnosed vaginal bleeding
- When follow up cannot be assured

Consider referral for specialist management if previous prolapse surgery using mesh.

If the vagina is not adequately oestrogenised offer vaginal oestrogen treatment as there is good evidence that this improves comfort and effectiveness of pessaries. It also reduces the risk of erosion.

Types of Pessaries available:

PVC ring pessaries:

Sizes: 52-80mm in 3mm increments 80-110mm in 5mm increments

Silicone pessaries:

There are a range of shapes and sizes. The following are available on an FP10:

- Ring: Sizes 44-127mm
- Ring with support: may be helpful if cystocele present. Sizes 44-127mm
- Gelhorn short and long stem: second line option for higher degrees of prolapse - 38-95mm
- A range of other shaped pessaries are available but not via the drug tariff.

Some pessaries such as the Gelhorn or shelf designs are not suitable in sexually active women.
**Initial fitting of ring pessary**

- Examine patient and assess prolapse
- Estimate the size of pessary that will be required (tip: use PVC rings for sizing rather than silicone pessaries to reduce cost)
  - Insert fingers into the posterior fornix
  - Make note of where the fingers come into contact with the pubic bone
  - Spread fingers wide to measure the vaginal width
  - Remove fingers and compare to pessary sample
- Twist pessary to insert to posterior fornix
- Push anterior edge behind pubic symphysis to sit diagonally in the vagina

**Checking for correctly sited ring pessary**

- Should have slight movement, not too tight behind urethra
- Assess for comfort (should not be able to feel the pessary) and relief of symptoms
- Ask her if she has any discomfort when asked to cough, sit, stand, walk, empty bladder
- Re-examine to ensure ring remains in correct place and still feels the correct size
- If ring uncomfortable or too loose, try with a different size

**Patient advice**

- The need to contact the surgery for advice if she develops any new urinary symptoms including difficulty passing urine, following ring pessary insertion
- Review early if problems and no later than 6 monthly
- Some women opt to remove the pessary themselves – on weekly basis, wash in soap and water, leave out overnight and then reinsert. The review can then be at a year
Review procedure

**Ask**
- Do you like it?
- Is it working?
- Any complications/problems/issues? – including:
  - discharge,
  - discomfort,
  - smell,
  - cleaning, removing & inserting,
  - bowel habit,
  - voiding,
  - sexual activity.
- Do you want to keep on using it?

**Examine**
- Check position, comfort and effectiveness
- Remove pessary
- Perform a speculum examination to exclude vaginal or cervical ulceration/erosions

**Reinsertion**
Replace with a larger PVC if previous pessary now too loose but if size correct consider use of a silicone ring which can be re-used. If size appropriate but ring pessary ineffective consider silicone ring with support or Gelhorn pessary

For silicone pessaries

- Wash pessary in soap and water to remove any powder prior to insertion
- Rotate rings and rings with support through 90 degrees after insertion such that hinges are lateral

Patient unable or unwilling to manage independently requires a follow-up appointment at a maximum interval of 6 months

Managing complications

**Vaginal discharge**
- May be normal foreign body effect
- Swab for microbiology and treat with appropriate antibiotic/antifungal if indicated
- Consider treatment is oestrogen cream/ring; non-oestrogen lubricant
- May need more frequent removal & cleaning

**Constipation**
- Dietary advice
- Check ring size and change for smaller size if appropriate
- Consider treatment with laxatives

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Erosions

- Swab for microbiology and treat with appropriate antibiotic/antifungal if indicated
- Pessary “rest”
- Consider adding or increasing vaginal oestrogen
- Non-oestrogen lubricant
- May need to change for smaller size ring if appropriate

De novo or worsening urinary incontinence

- Dipstix urine to exclude infection, haematuria or glycosuria
- Treat/refer if dipstix result abnormal
- Consider further investigations or referral to urogynaecology if necessary

Stuck pessary

- Consider referral
- May need to be removed under anaesthesia
- Patient, if fit for anaesthetic, may opt for surgical repair of prolapse at same time
- Risk of fistula if remains in-situ real but low – in very medically unfit may be better to leave and accept risk. Needs gynaecologist referral.

Post-Menopausal Bleeding

- DO NOT assume PMB is due to the ring pessary
- Organise fast-track referral especially in absence of significant erosion

Forgotten pessary

- Potential complications of infection, chronic discharge and odour, the ‘stuck’ pessary, fistulae
- Caution with ‘office’ removal if seems stuck because of risk of trauma and haemorrhage
- Use vaginal oestrogen daily for 4-6 weeks before attempting removal

TIPS:

- If a pessary change is very uncomfortable for a woman, consider use of vaginal oestrogens and/or applying Instillagel before the change
- Gelhorn pessaries can be difficult to remove as the vacuum between the disc and cervix/vagina needs to be broken. Using syringe to inject sterile water into the stem through the hole can facilitate this.
Competency requirements

Practitioners take responsibility for, and are accountable for, the care they offer. Their training and updating should meet the requirements and standards so they are competent to provide the service (initiating and changing or just changing ring pessary).

- Be competent to stage prolapse
- Be competent to communicate effectively about the management options including the use of a ring pessary
- Initial insertion – be able to perform abdominal and pelvic examination to exclude abdominal or pelvic cause for prolapse. Ref RCN bimanual competency training. Reference 6 (see references)
- Be competent to perform speculum examination
- Be competent to undertake vaginal swabs
- Be able to manage/advise about the use of topical oestrogen (ref PCWHF guidance on management of GSM)
- Be competent to assess when ring pessary treatment is no longer required

A competent practitioner within the scope of their role will be able to demonstrate:

- Sufficient knowledge and skill within their role to ensure safe and effective practice
- Recognition of his/her limitations of expertise and knowledge

All practitioners will be expected to perform an appropriate number of procedures each year to maintain their own professional standards.

Peer support and clinical supervision

It is important that practitioners do not work in isolation and take the opportunity to meet with other practitioners to share and critically reflect on their experiences, learning and preparation for appraisal.

Clinical audit and service evaluation

Systems for documenting results and management should be maintained for audit and service evaluation purposes to demonstrate effective and quality service delivery. For example, an annual audit including the number of procedures performed.

Training standards

Initial assessment

- Observe 2 procedures.
- Be observed performing a minimum of 2 satisfactory procedures.

Follow-up and refitting ring pessaries

- Observe 2 procedures.
- Be observed performing a minimum of 2 satisfactory procedures.
**Documentation Requirements**

All women undergoing this procedure should give informed consent for the procedure to be carried out.

**Recording requirements:**

- Size of pessary, LOT number and expiry date
- Make of pessary
- Side-effects or complications of ring pessary treatment
- Fit of pessary and control of prolapse
- Vaginal appearance

**Criteria for ongoing accreditation**

Continue to perform 6 satisfactory procedures/year to maintain competency

Audit and reflect on complication rates.

**References**

PCWHF Guidance on diagnosis and management of urogenital atrophy or Genitourinary Syndrome of the Menopause (GSM) 2017.
Louise Newson and Carolyn Sadler.

Guideline on the use of support pessaries in the management of pelvic organ prolapse. Continence foundation of Australia.


3: Atnip SD Pessary use and management for pelvic organ prolapse Obstetric and Gynecology Clinics of North America. 2009; 36 (3) :541-3


6: Royal College of Nursing, rcn.org.uk General examiner in woman, a resource for skills, development and assessment.
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