Royal College of Obstetricians & Gynaecologists

BSUG
British Society of Urogynaecology
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BSUG Guidance on management of Urogynaecological Conditions and Vaginal Pessary use during the Covid 19 Pandemic

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Objectives: The aim of this guidance is to reduce the person to person transmission of the virus causing Covid 19 and to best utilise medical and nursing resources in this time of national medical emergency.

General Guidance:

Most patients seen in Urogynaecology clinics present with non-urgent conditions such as prolapse and/or incontinence. There would be very few situations where they would present as an acute medical emergency or where an emergency admission to hospital is required. It is also important to remember that a large proportion of these patients are over 60 years of age making them more vulnerable should they contract Covid 19 as they are more likely to require hospitalisation. The BSUG therefore recommends a pragmatic approach to the management of patients attending the Urogynaecology clinics and recommends the following guidance for identification of patients that require a face to face consultation/review and the times frames in which they should be seen.

Women with vaginal pessaries are a particular group who require regular follow up, often performed within the secondary care environment. We would recommend telephone consultations in the first instance where most women can be reassured that a slight delay of a few months to the pessary change will have no harmful effects. This telephone consultation can also be used to identify which patients can have a delayed review (over 3 months), within 30 days and those who need to be seen semi-urgently.

When women are asked to come in for face to face review, it should be ensured that they are not symptomatic for Covid or in an extremely vulnerable group. If this is the case, their review should be deferred where possible and until safe to do so.

Emergency/urgent Review (within 12 hours):

***Urinary retention**:*

Patients presenting with urinary retention (postnatally or otherwise) if newly diagnosed need an urgent review to prevent bladder injury. It may be possible to see these patients within a gynaecology/ postnatal ward where nurses/midwives are trained to catheterise patients and monitor residual urine. The initial management will usually be with an indwelling catheter with a review in a week for a Trial Without Catheter (TWOC).

Semi-Urgent review (within 7 days)

Trial Without Catheter (TWOC):

Patients requiring a TWOC need to be seen to ensure their post void residuals are within normal ranges (follow hospital guidelines). If post void residuals are raised patients should be taught self-catheterisation where appropriate to avoid repeat admissions to hospital. It may be possible to defer TWOC for few weeks but this needs to be reviewed on a cases by case basis, especially for those patients who may have been in contact with a suspected or COVID positive person, or have symptoms themselves.

Fistulation from a pessary:

Severe problems arising from a pessary left in situ are relatively rare. When they occur it is usually in relation to Gelhorn and shelf pessaries. When this occurs a review within 7 days may be required for removal of the pessary.

Early review (within 30 days)

Pessary review for problems:

Where it is identified that the pessary is causing problems such as bleeding, pain or ulceration, patients should be asked to attend for a face to face consultation provided they fulfil the aforementioned criteria (they are not symptomatic for Covid or in an extremely vulnerable group). Post-menopausal bleeding in women with intact uterus and a vaginal pessary for prolapse should be referred via the local post-menopausal bleeding cancer pathway.

Procidentia causing bladder and bowel problems:

In patients with sudden onset of complete procidentia when they have bladder and bowel problems may need to be reviewed within 30 days. If however this is a long standing condition and the condition causes minimal inconvenience then review may be delayed.

Up to 3 months:

***Suprapubic catheter changes*:**

Change of suprapubic catheters can be delayed for up to 3 months. Where feasible a district nurse may be asked to visit the patient and perform the change at home to avoid a visit to the hospital.

After 3 months:

***Pessary review (routine)*:**

All routine ring pessary changes may be delayed for 3 months in the first instance and up to a total of 6 months from when the last change was due. For shaatz, gell-horn, shelf or double pessaries review/delay should not be beyond the 3 months from when the change was due. When left in situ for longer than 6 months the risk of ulceration and incarceration[1,2,3] increases. This usually presents with symptoms such as discharge and bleeding. Patients should be given a contact number should they develop problems while they are waiting for a review for a change of their pessary.

***New Referrals of prolapse and incontinence patients*:**

Most new referrals to the Urogynaecology clinic can be deferred whilst the directive for social distancing and staying at home is in place. Telephone consultations may be feasible which will only be able to continue with an adequate medical and nursing workforce. For urinary incontinence a virtual consultation will permit an assessment of the type of incontinence and preliminary advice to be given over the phone. Information sources can be provided which will allow commencement of initial treatment. For prolapse patients however, where the assessment and examination of the patient is key to further management and discussion of the various options for treatment, a telephone consultation is more limited in value.

Outpatient treatments/investigations:

These include procedures such as PTNS treatment, bladder instillations, Botox injections, Urethral Bulking agents and diagnostic cystoscopy (non-cancer indications). These are non-urgent procedures and should be suspended for the duration of the Covid pandemic crisis. These can be resumed again once normality returns.

References:

1. *Frenando RJ, Sultan AH, Thakar R, Jeyanthan K. Management of neglected vaginal ring pessary. Int Urogyn J. 2007; 18 (1):117.*
2. *Wu V, Farrell SA,Baskett TF, Flowerdew G. A simplified protocol for pessary management. Obstet Gynecol. 1997; 90:990.*
3. ***Propst K, Mellen C, O'Sullivan DM, Tulikangas PK. Timing of Office-Based Pessary Care: A Randomized Controlled Trial. Obstet Gynecol. 2020;135(1):100–105.***

This guidance has been produced rapidly to meet a need without undergoing the usual level of peer review scrutiny due to the current emergency. It does not form a directive but should be used by individual health care practitioners to inform their practice.