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THE CONTINUED USE OF VAGINAL PESSARIES IN THE TREATMENT OF UROGENITAL PROLAPSE

Hypothesis / aims of study

To identify parameters that predicts continued successful use of vaginal pessaries at six months.

Study design, materials and methods

Prospective observational study of 100 women referred with prolapse to this busy Urogynaecological tertiary referral Centre. Ethical approval was obtained.

Consecutive new referrals with vaginal prolapse were seen by one of two registrars in a weekly specialist clinic from September 2002 to date. All women with predominantly prolapse symptoms were invited to join this study. All subjects underwent the Pelvic Organ Prolapse Quantification examination (POPQ) in the semi recumbent dorsal lithotomy position after having voided. The women were also asked to complete the Pelvic Floor Distress Inventory (PFDI) and the Pelvic Floor Impact Questionnaires (PFIQ) at baseline and at six monthly intervals. The women were all seen and counselled in a standard way. The options they were offered were

1. Do nothing
2. Try a vaginal pessary
3. Undergo surgery

Those who opted to try vaginal pessaries were fitted with vinyl ring (Mentor, UK) or Simpson shelf (B Braun Medical Ltd, UK) pessaries. The women were offered rapid access back to the unit if they had any problems with the pessaries. They were reviewed by the same doctors six months later.

Results

To date, 137 women have been recruited to this study. Baseline POPQ was stage one in 5.8%, two in 45.3%, three in 38.7% and four in 10.2% of cases. 105 women (77%) agreed to try vaginal pessaries and the remaining 32 (23%) declined due to previous trial of pessary or simply not liking the idea. 23 (22%) out of the 105 women were still using the pessaries at the six month review. In 56 cases the pessaries fell out. In 46 (82%) of these, the pessary fell out within 24 hours. The remainder fell out between two and ninety days. In 15 cases the pessaries were taken out between one day and six months later due to discomfort or dissatisfaction. Nine women who have tried pessaries have yet to be seen at their six month review. The only significant predictors of unsuccessful use of pessary at six months were a previous hysterectomy ($p=0.001$ χ^2) and a longer perineal body ($p=0.005$ Mann Whitney U). The median perineal body measurement in the women who continued with pessaries was 2.00cm compared to 2.50cm in the unsuccessful group.

Interpretation of results

Trial of pessary was only successful in one fifth of women referred to a tertiary centre. The only POPQ parameter that achieved significance in predicting this group is a shorter perineal body but this is unlikely to have clinical significance due to the small difference in measurements involved. POPQ stage did not seem to influence successful use of pessary. Women with previous hysterectomy were less likely to benefit from pessary therapy. Quality of life scores and demographic data did not discriminate between successful and unsuccessful pessary users.

Our study did not demonstrate the high rate of successful use of vaginal pessaries reported by other authors, but this may be due several factors. The range of pessaries readily available is limited in the UK compared to the United States. Also, British women are not experienced at handling and replacing their own pessaries, which is common practice in the United States. Therefore, in the UK, pessaries are usually changed three to six monthly by health care workers. Consequently, amongst the sexually active in this study, shelf pessaries could not be used. In addition, more advanced prolapse may predominate in a tertiary centre setting which

may influence use of pessary. Also successful use of pessary was assessed at six months rather than one week which may explain, in part, the lower success rate found in our study.

Concluding message

The use of vaginal pessaries in the UK is helpful in some women. However, women who have had a previous hysterectomy are less likely to benefit from pessary treatment. Due to the well accepted risks of surgery including the need for further prolapse surgery[3] and financial implications, conservative measures should be considered in all cases.

References

1. A Survey of Pessary Use by Members of the American Urogynaecologic Society. Obstetrics and Gynaecology, June 2001.Vol 95; 6(1).
2. Risk Factors Associated with an Unsuccessful Pessary Fitting Trial in Women with Pelvic Organ Prolapse. American Journal of Obstetrics and Gynecology, 2004. 190; 345-50
3. Cost of Pelvic Organ Prolapse Surgery in the United States. Obstetrics and Gynaecology, October 2001. vol 98; 4.