Nonsurgical Treatment for Pelvic Organ Prolapse: Calling on Nurses for Pessary Fittings

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Pelvic organ prolapse (POP) and urinary incontinence are common conditions that significantly affect quality of life for many women. Current treatment options include nonsurgical and surgical interventions; both have proven efficacy. Although surgical repair of POP is the only “cure” for this problem, nonsurgical options have been shown to satisfactorily manage symptoms of prolapse and urinary incontinence. This article briefly reviews the definition and clinical presentation of POP and discusses the use of a pessary for nonsurgical treatment.

What is POP? The female pelvic floor is complex, and its function is dependent on musculoskeletal connections to pelvic bones to support the abdominal and pelvic viscera. The organs supported by these connections are the bladder, uterus, vagina, and rectum (see Figure 1). The pelvic floor often is described as a hammock whose attachments to the pelvic bones secure the pelvic organs in their proper place. When the musculoskeletal connections are broken or stretched, POP may occur. POP's causes are multifactorial and consistently associated with multiparity, hysterectomy, family history, increasing age, and chronic constipation.

Figure 2 illustrates various forms of prolapse. A cystocele is the most prevalent type of prolapse and represents at least half of all cases. When a cystocele occurs in combination with another type of prolapse, it most often is a rectocele, where the rectum herniates. A prolapsed uterus used to be treated strictly by a hysterectomy, but more recently procedures have been aimed at preserving the uterus. This, in part, is because some now believe removal of the uterus precipitates a risk factor for prolapse of other pelvic organs because of the space created by its absence and the trauma of the surgery itself to supporting ligaments and muscles.

POP is classified in stages and compartments to enhance clinical understanding and provide enhanced description. The compartments classify the location of the prolapse and include anterior (bladder), posterior (rectum), apical (cervix/uterus, vaginal apex), and perineal. Stages are used to describe the anatomic severity of the prolapse and are measured using the Pelvic Organ Prolapse Quantification (POPQ) examination with maximum valsala effort (see Table 1).^2^

**Symptoms.** POP is a very common condition. Stages I and II have been demonstrated in up to 50% of women who have had a vaginal delivery. However, only 20% of symptomatic women seek care. Women with prolapse often complain of visualization or sensation of a vaginal bulge and pelvic pressure or heaviness that may be constant or that occurs with increased activity. Symptomatic prolapse also presents with other pelvic floor disorders such as overactive bladder, difficulty voiding/defecation, urinary/fecal incontinence, and sexual dysfunction. Women may experience bothersome symptoms even with Stage I prolapse, as well as at higher stages.

**Surgical/definitive treatment.** Women with symptomatic prolapse have nonsurgical and surgical options for its treatment and symptom relief. Surgical treatment is the...
only “cure” for POP and aims to re-establish the attachment of the vaginal apex to pelvic ligaments; correct connective tissue defects in the anterior (bladder) and posterior (rectum) vaginal wall; and return the normal vaginal axis. The decision to proceed with surgical repair should be made with consideration to: 1) POP severity; 2) patient desire for definitive management; 3) patient expectations for symptom relief; 4) desire for sexual activity; and 5) patient comorbidities. Eleven percent of women will undergo surgery for incontinence or prolapse. Although success rates have been found to be 75%, at least 29% of women who have one prolapse surgery may require repeat surgery. As such, if definitive treatment is not desired, a nonsurgical route should be considered.

Nonsurgical treatment. One nonsurgical approach involves use of a pessary. Pessaries are silicon devices placed inside of the vagina to support pelvic organs in the anterior, apical, and posterior compartments. Pessaries are designed in a variety of shapes and sizes to individually correct different types of prolapse (see Figure 3). Pessary use should be considered for women who have well-estrogenized vaginal epithelium (or women willing to use vaginal estrogen to prepare the epithelium) and women who are comfortable with placement and removal of the device in the vagina.

Pessary fitting. Pessary fitting is accomplished by trial and error. Therefore, a fitting visit should allow adequate time. A well-fitted pessary is retained in the vagina with valsalva (in lithotomy and standing position), while walking, and while toileting. A properly fitted pessary should be barely noticeable. The effectiveness on symptom relief may not be realized until after continued use.

Pessary care. Pessaries require upkeep and need to be removed and cleaned on a regular basis. The ring and dish pessaries can be removed daily and cleaned. Donut, cube, and gelhorn pessaries can be retained in the vagina for 1 to 3 months and often are removed and cleaned in the office. Most women can learn to care for their pessaries themselves. Vaginal estrogen cream should be used at least three times per week with all pessary use to maintain normal vaginal epithelium and to reduce the risk of ulceration. Pessaries should be removed before sexual intercourse.

Clinicians need to discuss both nonsurgical and surgical options with patients with symptomatic POP, particularly given the recently raised concerns about the safety and efficacy of transvaginally placed mesh in POP repair. Although many patients undergoing mesh-augmented vaginal repairs heal well without problems, a small but notable group of these patients experience permanent and life-altering consequences, including ongoing pain and dyspareunia, based on limited data to date. Nonsurgical options are appealing to many women; more nurses should be specially trained in pessary fitting. It is an easily acquired skill, enhanced with experience. Take on the challenge!

References