Use of Vaginal Pessary in Geriatric Women

Colleen Mellen, MS, CNS, APRN
Hartford Healthcare Medical Group
Urogynecology Division
Hartford CT
colleen.mellen@hhchealth.org
Disclosures

- I have no relevant financial relationships to disclose
Objectives

Special considerations for use of pessary in the geriatric woman:

- Discuss counseling and preparation for trial of pessary
- Describe pessary fitting
- Describe routine pessary follow-up, surveillance exam
- Describe management of complications
- Discuss when to terminate use of pessary
Pessary fitting and Maintenance References

- [www.uptodate.com](http://www.uptodate.com) Vaginal pessary treatment of prolapse and incontinence. Author: Jeffrey Clemons, MD, FACOG. Literature review current through: June 2018, Topic last updated Feb 08, 2018
Geriatric Women - Definition?

- No precise definition of when adults become geriatric. Age > 65 often used as starting point to define “geriatric” population.
- By 2030, estimated > 20% of the U.S. population, or 1/5 people, will be 65 years of age or older [1].
- Adults often remain physically active, independent, do not require geriatric expertise for healthcare until age 70 to 75 or older. Women in the U.S. have a higher life expectancy than men [2,3].
- By 2020, projected > 50 million women in the U.S. will be postmenopausal [4].
- ***Women are expected to live about 40% of their lives after menopause***
Pessary and Geriatric Women: ROL

- The percentage of women reporting at least one PFD increases with age: 9.7% age 20-39 to 49.7% age > 80 [6]
- Older women are more likely than younger women to choose pessary for treatment of POP, SUI [22,23,24]
- Women age >65 years, with severe comorbidities more likely to use pessary long-term compared with women ≤ age 65. [13]
- One large scale retrospective review of CMS data for 34,782 women >65 years, with a diagnosis code of POP, and billing code for pessary fitting found only 4019 (11.6%) were treated with pessary [35]
Natural history of pessary use in women aged 65-74 versus 75 years and older with pelvic organ prolapse: a 12-year study [49] Ramsay et al. 2015

- A retrospective cohort study of 304 women >65 undergoing pessary fitting at Urogynecology clinic in Quebec, Canada reported:
  - Women with hx of hysterectomy or pelvic reconstructive surgery were more likely to fail initial pessary fitting
  - Women aged 65-74 and women aged 75+ years continued pessary use 87.5% vs 80.8% at one year, 80.6% vs 70.9% at 2 years and 62.1% vs 37.8% at 5 years
  - Erosions occurred in 19.3% of long-term users (> 1 year)
  - Vaginal erosions were > 3 x’s more likely to occur in women 75+ years
Contraindications:

- Non-adherence to follow-up maintenance schedule
  - Lack of transportation, family, or community support
  - Medical/ mobility problems
  - Dementia/ Cognitive impairment
Pessary complications: Low Risk, but not No Risk [19]

Common:
- Vaginal discharge
- Odor
- Irritation

Less Common:
- pain
- Infection
- Erosions
- Vaginal bleeding
- Obstruction or urination or defecation

Rare: (usually associated with neglect)
- Incarcerated pessary
- Vesicovaginal or Rectovaginal fistula
- Small bowel incarceration
- Fecal impaction
- Cervical entrapment
- Pyelonephritis
- Hydronephrosis and urosepsis
- Vaginal or cervical cancer
Factors related to major pessary complications in geriatric women [31]

- Prolonged Pessary use, years to decades
- Advanced vaginal atrophy
- Cognitive Impairment
- Change in healthcare provider: loss of information that pessary is in place
  - Use diagnosis code *Vaginal pessary in situ Z92.89* in EHR or
  - Use diagnosis code *Vaginal pessary present Z92.89* in EHR
- Transition of residence: home ➔ rehabilitation center/assisted living ➔ long-term care
Pessary Fitting

- Patient Assessment
- Counseling
- Preparation
- Fitting
- Education
Patient Assessment:

- Dementia/ cognitive impairment
- Support system, Transportation for follow-up
- Mobility level
- Medical comorbidities
- Current medications/allergies
- Anticoagulants
- Incontinence products
- History of pelvic surgery, hysterectomy, previous prolapse or incontinence surgery, use of mesh
- Prescription drug coverage
Patient Assessment:

- **Most bothersome symptom(s)** [16]
  - Bulge, pressure, urinary leakage, nocturia...

- **Address fears and concerns regarding pessary use**
  - Will it hurt?
  - Will it fall out?
  - Will I get an infection?
  - Do I have to clean it?
  - What do I have to do? Do I have to touch it?
  - What are my activity restrictions? Shower? Swim?
  - Will everyone know that I am wearing pessary?
  - What about sex?
Patient Assessment:

- **Patient goals** for use of pessary, personal and social factors [16]
  - Preference for non-surgical treatment - belief “too old”
  - Relief of symptoms:
    a. Bulge, pressure
    b. Incomplete bladder emptying, voiding dysfunction
    c. Urinary incontinence: SUI, UUI, nocturia
    d. Recurrent UTI’s, vulvovaginal irritation
    e. Constipation, defecatory dysfunction
    f. Difficulty walking, low back pain, hip pain
    g. Comfortable “going out” for social activities

ARE GOALS REALISTIC?
What can pessary do/ not do?
Counseling

- Review patients individual exam findings: use diagrams, look with mirror
- Patient preference for self-management
- Sexual Activity
- De novo SUI
- Pessary selection
- Pessary complications, warning signs
- Follow-Up schedule, patient responsibility
- May take more than one visit to determine best pessary size or type. [5] (May incur additional charges)
Placement of pessary in vagina
Counseling:
Address safety issues

- Importance of keeping scheduled follow-up visits
- Review warning signs of pessary complications to notify provider for
- Informed consent
- **Enlist family/ social support**
- Suggest Medi-alert bracelet
- Provider appointment reminder system or follow-up log
PESSARY PATIENT INFORMATION

You have been fitted with a _________________________________ Pessary

GENERAL INFORMATION

Pessaries are used for non-surgical management of pelvic organ prolapse. Some pessaries can help manage urinary incontinence. Normally causes no pain or discomfort.

Regular hygiene is all that is required.

If you are able to remove and clean your Pessary please remove and clean your Pessary at home every _________________________.

Use a mild soap, such as Dove bar soap or Cetaphil gentle liquid cleanser to clean your Pessary at home. AVOID antimicrobial soaps. No sterilization is required.

You are not required to care for your Pessary on your own if you do not wish to.
VAGINAL DISCHARGE
Some mucous-like discharge is normal.
Some vaginal odor is normal but it should not be foul smelling.
You should not experience any increased vaginal itching or burning.
There should not be unusually large amounts of vaginal discharge.
Please call the office if you have vaginal bleeding (pink, bright red to dark brown discharge).

USE OF VAGINAL CREAMS
We sometimes recommend use of vaginal estrogen creams with pessary to maintain the health and strength of vaginal lining.
Vaginal estrogen creams are not needed if still menstruating.
You have been prescribed ____________________________. This medication is to be used ____________________________
The risks/ benefits/ alternatives of vaginal estrogen creams were discussed ____

Vaginal lubricants and moisturizers can also be used but these preparations do not prevent vaginal sores or heal the vaginal lining.
You have been recommend to use ____________________________
Informed Consent/ Patient Responsibility
Draft

COMPLICATIONS ASSOCIATED WITH PESSARY USE [MOST COMMON WITH NEGLECTED PESSARY]

Vaginal infections (bacterial/fungal)
Vaginal bleeding.
Vaginal erosion (open sore in vaginal lining)
Vaginal fistula (hole between vagina and bladder or rectum)
Pessary incarceration (Pessary that is “stuck” in the vagina and may need a procedure to remove).

I understand that failure to follow up with scheduled Pessary checkups can result in vaginal wall erosions and other serious complications

Please call the office at (860) 972-4338 if you experience any pain, foul vaginal discharge, bleeding, or if you are unable to urinate or pass bowel movement. If your Pessary falls out and you are unable to reinser it, or if you have any further questions regarding the care of your Pessary, don’t hesitate to call.

Please call the office at (860-972-4338) if you need to reschedule your Pessary checkup appointment.

I have read and understand these instructions. I am also aware that fitting pessaries is not a perfect science and that type and/or size may need to be changed periodically with extreme weight loss/gain, after vaginal surgery or with changes in condition. I will be responsible (billed to insurance) for the cost of each additional Pessary which is used in finding the Pessary that will take care of my problem(s).

_______________________________________________  __________________________
Patient Signature                                                                             Date

_______________________________________________  __________________________
Provider Signature                                                                             Date
Prepare for pessary placement:
Education & Treatment re genitourinary syndrome of menopause (GSM)

- GSM “constellation of signs and symptoms secondary to a decrease in estrogen and other sex steroids” [32]

- Physical signs symptoms: in the labia majora/minora, clitoris, vestibule/introitus, vagina, urethra, and bladder” [32]

- GSM is directly related to a decrease in circulating estrogen after menopause, resulting in anatomic, physiologic and clinical changes to the genitourinary tract and sexual function. It is a progressive, but treatable condition. [32]

- GSM signs and symptoms may need to be addressed first or concurrent with pessary fitting
Prepare for pessary placement

- Treat signs & symptoms of advanced vulvovaginal atrophy (GSM)
  - Sample regimens: expert opinion [5]
    - Estrogen cream 0.5-1.0 gm with applicator 2-3 nights per week for 2-4 weeks before trial of pessary
    - Fingertip application of cream to introitus Q HS prior to pessary fitting

- Treat constipation- may make pessary fitting difficult/ uncomfortable
Preparation: Treat Incontinence associated dermatitis (IAD) and vulvar contact dermatitis

- Sensitive skin/ pH balanced cleanser for peri-care
- Use appropriate incontinence absorbent pads rather than menstrual pad or menstrual mini-pad (no preservatives, fibers that wick-away urine)
- Use barrier ointment to protect skin from acidic urine/mechanical friction from pad
- Sensitive skin laundry detergent, no dryer sheets or fabric softener
  - Diane Newman, AWHONN Seattle, 2000
Pessary Fitting: Two types of pessaries
Both can be used in Geriatric Women

- **Support pessary**
  - 2-D fitting the long axis of the vagina
  - Require introitus integrity to retain
  - Easiest for patient to remove and insert
  - Sexual intercourse may be possible with pessary in place
  - Includes incontinence pessaries

- **Space-filling or self-retaining pessaries**
  - 3-D to fill vagina/ may have concave portions
  - Used with Stage III or IV POP
  - More difficult for women to remove on their own
  - Sexual intercourse often not possible with pessary in place
Support Pessaries:

All pessary photos courtesy of Cooper surgical, Pan Pac
Self-Retaining/
Space Filling Pessaries:
Pessary fitting: patient comfort, positioning and safety

- Assist with undressing if needed
- Use electronic, adjustable exam table
  - Assist on and off exam table
- Head elevated to accommodate breathing
- Adjust stirrups to accommodate hip/knee problems
- Limit number of postural changes to avoid lightheadedness, postural hypotension
- Position yourself so patient can see your face when speaking. Use assistive hearing devices
- Arrange office equipment to eliminate fall risks
Preparation: “Will it hurt?”

lidocaine-prilocaine cream

- Some women experience pain, or have anxiety in anticipation of pain with pessary insertion and removal.
- One study compared lidocaine-prilocaine cream pretreatment with a placebo cream. 4 g lidocaine-prilocaine cream applied 5 minutes before pessary insertion or removal, reduced patient-reported pain [30]
Pessary Fitting Guidelines

- Start small and work up
  - POP Q: Especially TVL, GH, leading compartment of prolapse
  - *POP Q exam does not assess: introitus width, vaginal caliber, pelvic floor muscle atrophy, shape of pelvic bones which all influence pessary fit [5]
  - The largest comfortable pessary should be used
  - At the initial visit, approximately 85% of women with POP can be fitted with pessary [26]
  - Several sizes often need to be tried. May take 2-3 visits to establish best pessary fit. [5]
Pessary fitting: Vaginal length, Introitus width
Pessary fitting: vaginal caliber, vaginal vault
Pessary fitting guidelines: sample [5]

- Try **Ring pessary first**
  - if vaginal introitus size is 1-2 fingerbreaths & POP is stage II-III

- Try **Gellhorn pessary first**
  - if vaginal introitus is 3-4 fingerbreaths and/or stage IV POP
Fitting/ Refitting decisions: sample

1. Adequate introital integrity Try ring with support

2. Pessary falls out Try self-retaining

3. De novo SUI Try incontinence device
Case 3: 74 yo female with urinary urgency, frequency, must reduce prolapse manually to void. Uncomfortable to sit.
Satisfied Patient:
Pessary Fitting: Trouble shooting
Predictors for unsuccessful pessary fitting in geriatric women[20]

- Short vagina (< 6 cm)
- Wide introitus (>4 fingerbreadths)
- Distal posterior wall prolapse (rectocele)
- Previous vaginal surgery (apical narrowing)
- Coexisting or new onset SUI
Problem:
Wide Genital Hiatus: Pessary slips out with straining.

rotate pessary
¼ turn- make rigid
Problem:
Narrow introitus, vaginal canal, apex
Try oval pessary or small gellhorn
Complaint of Rectal Pressure

Try Shaatz pessary (thinner profile rim) instead of ring
Problem: Shortened vaginal length
use Gellhorn Pessary
1” stem vs 2” stem
Problem: New onset SUI with pessary in place:
Unmasking of Occult SUI associated with prolapse
Use Incontinence Pessary or Consider pessary plus urethral bulking

- Urinary Incontinence with prolapse
- Increases urethral closure pressure
- Stabilizes urethrovesical junction
Procidentia:
Cube pessary with drainage holes, Tandem cube or double pessary (ring + Gellhorn, donut + Gellhorn) [38]
Patient can not remove pessary for self-care:
Tip: Pessary removal with Dental floss/ dental tape
All attempts at pessary fitting failed: Consider support undergarment, or pregnancy support belt [34]
Education: pessary self-care

Women to care for pessary themselves experience fewer complications [19]

- Demonstrate with patient participation
- Have patient practice insertion and removal
- Give lots of positive reinforcement
- Enlist the help of spouse, partner or family member to learn how to remove/ reinsert pessary
- Review wearing schedule, cleaning and maintenance
- Provide contact information for patient questions
**Education: Vaginal Estrogen, Vaginal Moisturizers**

- Discuss purpose, mechanism of action, risks/benefits/alternatives, dosing & schedule, application techniques
- Determine best type of product (cream, tablet, ring) for maximal adherence based on patient dexterity, time schedule, memory deficit
- **Contact patient’s Oncologist** if concerns about patient history of breast cancer, gynecologic cancers for approval to use vaginal estrogen
- **Demonstrate application of vaginal estrogen cream, tablet, ring or vaginal moisturizers with patient participation** in drawing up dose (if cream or gel) and applying in vagina
- Demonstrate fingertip application of vaginal cream or moisturizers if using this method.
Pessary Fitting Summary: Allow time

- Pre-treat with Lidocaine cream if indicated
- Digital exam to size
- Decide on pessary
- Insert pessary
- Have patient bear down, cough (supine & standing)
- Stand, sit, walk, urinate, valsalva while on toilet before leaving

***Slow postural changes to avoid lightheadedness/ postural hypotension

- Re-examine patient in standing position to check if pessary “slips” with cough
- Discuss follow-up appointment
- Discuss use of vaginal moisturizers, topical estrogen- when indicated
  - Demonstrate application of topical estrogen with patient participation
- Provide contact information for patient questions
Pessary maintenance follow-up & Surveillance exam
Timing of Pessary Follow-up: How often?

- **Initial follow-up visit:**
  - No consensus on time interval for first pessary check, 1-3 days (manufacturers recommendation); 1-2 weeks [5], 2-4 months [33]

- **On-going Follow-up maintenance visit:**
  - Every 3 months (common practice in US, 70% of APP’s Q 3 months ) [39]
  - Recommended Pessary Quality Care Indicator: Follow-up at least every 6 months: AUGS Expert Panel, Anger, JT et al, 2013
  - Individualize based on:
    - Type of pessary: support vs space filling
    - Tissue response: intact vs vaginal epithelial abnormality (VEA) [39]

- **PAPER 37: Timing of Pessary Care study.** Propst, K, Mellen, C, O’Sullivan, D, Tulikangas, P. AUGS 2018 First randomized, controlled study comparing traditional 3 month follow-up (US) vs 6 month follow-up (European model) comparing epithelial abnormalities, unplanned visits, patient satisfaction.
  - Return every 6 months to 1 year for patients managing pessary on their own [39]
Return visit symptom review:
“My pessary is NOT working”

- Lower urinary symptoms
- Bowel status
- New onset SUI
- Abnormal discharge/ bleeding/ odor
- Pelvic pressure/ pain
- Bulging past pessary
- Sexuality/ QOL issues
- Current self-care habits
- Adherence to prescribed vaginal estrogen or topical gel
Pessary follow-up surveillance exam:

Components

- Pre-treat with Lidocaine cream if indicated
- Remove pessary, Clean pessary
- Visually inspect
- Vaginal epithelial abnormalities (VEA) [Tulikangas 2018] rule-out at each follow-up visit
- Vaginal exam/ speculum exam-careful evaluation of posterior fornice
- Rectovaginal exam, if thinning of tissues posterior fornix to evaluate for fistula
- Silver Nitrate if minor vaginal epithelial disruption/ granulation tissue [40]
Pessary follow-up: Surveillance
Vaginal bleeding, discharge, erosions
Pressure points of pessary  Apex is 2-4 mm thick post-hyst [46]
Pressure points, Mechanical friction related to pessary

[K. O’Dell]
Pessary follow-up exam: Equipment
Pessary Follow-up: Decision making

Decision to:

- **Treat** minor vaginal epithelial disruptions in-office
  - Silver nitrate [40]
  - Topical estrogen applied
- **Re-insert**
- **Refit** - different size or type
- **Remove** - Leave out if erosions [pessary holiday]
- **Continue or start treatment for vaginal atrophy** with low-dose topical estrogen cream, tablet, ring. Demonstrate/ reassess use of local estrogen product
Management of complications secondary to pessary use

■ Etiology?
- Vaginal atrophy
- Mechanical injury
- Infection
- Inflammation
Common Complications:

**Discharge, Odor** - mechanical injury? Vaginal atrophy?

- R/O Erosion
- Refit using pessary with larger drainage holes or less occlusive
- More frequent pessary cleaning visits
- Prescribe
  - Vaginal moisturizer [41, 44]
  - Acidifier Hydroxyquinoline-based gel [42]
  - Estrogen [43]
- Temporary pessary holiday
- Change to alternate pessary manufacturer
  - expert opinion
Treatment of complications: Less Common but More Worry

Vaginal epithelial abnormalities (VEA)
- Vaginal bleeding, spotting, abnormal drainage
- Vaginal erosion aka Mechanical Pressure Ulcer
- Hypergranulation tissue
Terminology: Erosions-no consensus

- **Erosion** - size, depth? Any break in the epithelium?
- **Vaginal Epithelial Abnormality (Hartford FPMRS definition)**
  - Granulation tissue > 1 cm, Break in epithelium > 1cm [15]
- **Mucosal pressure ulcer**
  - Due to medical device in a moist lining of body cavity communicating with exterior (GI, tongue, nasal passages, GU, vagina)
  - -document location, surface circumference, friability
- **Hypergranulation tissue**
  - -abnormal build-up of mucosal granulation tissue due to chronic friction (ie pessary in vagina), in a process that impedes normal healing
  - Document location, size, friability [14]
Risk factors for vaginal erosion: [48]

- Erosion rate for this study sample retrospective chart review, 119 subjects
  - Average 16.8% erosion rate over 13 years
    - 1st year: 1.68%, by 13th year 50%
- Factors identified that increased the rate of erosion
  - Increase
    - Daily ASA use
      - Alone p < 0.001
      - When controlled for all variables
        - HR 2.794 (1.480 - 5.275), p=0.002
    - Greater Parity
      - Chance of erosion increases 27% with each additional child
        - HR 1.268 (95% CI: 1.036-1.553)
      - Theorize that greater parity may be associated with larger prolapse and need for larger pessary?
Risk factors for vaginal erosions secondary to pessary use: [48]

- Factors identified that decreased the rate of erosion
  - Use of Estrogen cream $p = 0.022$
  - ERT sub-analysis
    - Hysterectomy $p=0.048$, HR: 0.459 (0.212 - 0.995)
    - This finding is not consistent with other reports in ROL which state presence of cervix is protective against vaginal erosions.
Proposed Terminology: Mucosal pressure ulcer vs vaginal erosion [47]

- Mucosal Pressure Ulcer:
  - Due to medical device; moist lining of body cavity communicating with exterior (GI, tongue, nasal passages, GU, vagina)
  - Injury → inflammation/ bleeding → soft clot/ coagulum → easily shed (not slough)

- Problems with identification/ staging:
  - Initial shallow open ulcer difficult to see (background)
  - Tenderness/ edema don’t occur
  - Coagulum and slough are both yellow/ shiny

- Healing:
  - Similar to skin but no scar

[47] National Pressure Ulcer Advisory Panel, 2010
Mucosal Pressure Ulcer: erosion
Treatment options: mucosal pressure ulcers

- First Line: temporary removal
  - 2-4 weeks
- Vaginal estrogen
  - Nightly or twice a week while out
  - Widely used with little evidentiary support
- Consider refit—change size or style
- Apply cream under the pessary
- Learn more about mucosal ulceration from other disciplines (GI, dentistry)
Hypergranulation tissue:
another abnormal epithelial membrane response to mechanical injury
Treatment: Friable Hypergranulation Tissue

- Removal for 4 to 6 wks or longer ± topical estrogen
- Change size/shape of pessary ± topical estrogen
- **Chemical cautery** to remove abnormal granulation tissue/ promote re-healing
  - Silver nitrate
  - Ferric sulfate (Monsel’s) [40]
Options for treatment of vaginal atrophy [ACOG 2014] [Rahn, 2014]

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<th>Dosage</th>
<th>Evidence of Benefit*</th>
<th>FDA Approved</th>
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<td>• Ospemifene</td>
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Estrogen use and pessaries
What is the evidence?

- Vaginal Estrogen use associated with:
  - lower pessary discontinuation rates
    \[30.6\% \text{ vs } 58.5\% , \ P < 0.001\]
  - Less vaginal discharge
  - But did NOT decrease in vaginal erosions or vaginal bleeding
    - Retrospective chart review by billing code
    - Non-randomized; with > 6 months f/u [43]
  
- Estrogen users showed no significant differences in:
  - Level of comfort with removal/insertion
  - Adverse effects: discharge, bleeding, infection.
    - Prospective, non-randomized (n=120) [45]
Other potential vaginal treatments for vaginal epithelial abnormalities (VEA) secondary to pessary use:

- Estrogen agonist/ antagonist-Ospemiphene
- Hyaluronic acid sodium salt-ovule
- DHEA vaginal insert
- Dehydroepiandrosterone intravaginal
- Moisturizers/ lubricants
- Fractional CO2 Laser

No evidence to determine if these products have a role in improving risk of VEA’s secondary to pessary (related to mechanical irritation in background of vaginal atrophy)
Other etiologies: Infection
Bacterial Vaginosis?
Post menopausal microenvironment unchanged before and after pessary use

- Pessary use increases bothersome discharge in some women
  - New users vs established (>3 mos use): 2% v 30% p<0.001

- Prevalent organisms were the same in women who had never worn a pessary and those who had worn pessary for >3 months. 100 pessary uses with follow-up at 2 weeks, 3 months, 6 months. No change in organisms over time. No vaginal estrogen use (IRB requirement)
  - Cornybacteria, S. viridans, lactobacilli, E.coli, Bacteroides

- WBC per HPF increased within 2 weeks of pessary use, indicating inflammatory changes

- Based on these findings, current definitions and diagnostic criteria for BV do not adequately describe the normal post-menopausal vaginal microenvironment. [37]
Other etiologies: Inflammation?
New study

“Inflammatory response in women with vaginal epithelial abnormalities after pessary use”

Aim: to compare the profiles of women who develop VEA with pessary with women who do not develop VEA with pessary. Specifically assess concentrations of 2 pro-inflammatory cytokines to determine if they are associated with VEA.

Dr Aparna Ramaseshan
Dr Christopher Nold
Dr Paul Tulikangas
Colleen Mellen, APRN
David O’Sullivan PhD
Case 1: 84 yo, G1P1 women with procidentia, has worn Ring/ support pessary x 10 years

- Presented at age 74. Her presenting symptoms were vaginal bulge and pressure, sensation of incomplete bladder emptying, urinary urgency/ frequency.
- All symptoms resolved with size 5 ring with support
- After 2 years erythema/ thin appearing epithelium noted on exam at posterior fornix where rim of pessary rests. Pt prescribed estrogen cream, 1 g vaginally, twice weekly at HS, pt self-applied vaginal cream
- After 5 years, pt dx’d with early dementia, poor short term memory. Pt started Aricept. Her husband prompted her to use estrogen vaginal cream and to do timed voids during waking hours (c/o urge UI after “sitting all day”)
- After 8 years, pt developed persistent granulation tissue at posterior fornix, husband noted occ bleeding/ spotting on her pad. Bx showed inflammation. Pt could not apply own estrogen cream, husband was not aware. Husband taught how to apply vaginal estrogen (fingertip method) for his wife
- After 10 years, pt is combative when husband tries to apply estrogen cream. She has superficial vaginal erosions, vaginal bleeding/ tan drainage. She is very uncomfortable with pessary removal and insertion. Pt and husband have met with Urogynecologist x 2 to discuss obliterate surgery to address prolapse. Husband is fearful that pt will not be able to tolerate 1 night hospital stay. Arrangements made for him to be with his wife pre-op and post-op to provider support.
- Husband hesitant to consent for his wife to have prolapse surgery. Their son volunteers to stay with them one month post-op. Husband declines surgery. Pessary holiday x 2 to allow for healing of vaginal erosions. Pt had “constant urinary urgency/ frequency ” when pessary out. Estring (vendor sample) placed along with ring pessary. Patient seen frequently to assess vaginal lining.
Case 2: 75 yo female seen in ED for acute urinary retention
When to terminate use of pessary?
Terminate use of pessary in Geriatric woman:

- Patient desire for surgery
- Patient request for trial of pessary removal
- Vaginal epithelial disruptions cannot be managed with standard treatment (risk of bleeding/deep tissue ulceration/fistula)
- Risks outweigh benefits of pessary
Terminate Pessary in Geriatric Woman

- Patient can no longer be transported to office for pessary follow-up and surveillance
- No trained provider at long-term care facility for pessary maintenance
- Patient is no longer ambulatory
- Patient/ family choice when making end-of-life decisions (when patient comfort outweighs risk of urinary retention/ defecatory dysfunction/ vaginal excoriation related to prolapse)
Use of Vaginal Pessary in the Geriatric Woman: Summary
Advantages of Pessary for Geriatric Women

- Minimally invasive
- Avoids surgical risk & post-op complications [27]
- Accepted by patients, (42-100% with provider encouragement) [20,21,22]
- Provides effective, immediate, relief of prolapse, urinary and bowel symptoms [11,12,13,1,4]
- Improves body image and QOL [17,18]
- Achieve personal goal attainment [16]
- May be self-managed by patient
- May allow for continued sexual activity
Advantages of Pessary for Geriatric Women [5]

- Genital hiatus may decrease in size with pessary use, allowing a smaller or different shape pessary over time [28, 36]
- Made of medical-grade silicone (non-allergic, do not absorb odors, can be autoclaved)
- Contraindications, risks and complications are low [27]
- Minor complications (vaginal discharge, odor, bleeding, erosions) can be successfully treated [29]
- In the absence of major complications, pessary use can be continued for life [5]
- Pessaries have been a viable treatment for POP for centuries; still no clear guidelines for pessary fitting, follow-up, or management exist to date [35]
Recent new PFD risk factor to my extended family
Resources:
Patient Information
Pessary Care Guideline

Sample [33]
A vaginal pessary is a silicone device, similar to a vaginal contraceptive diaphragm, that is used to treat urinary incontinence or prolapse.

**About Vaginal Pessaries**
A vaginal pessary is inserted into the vagina to support dropped pelvic organs and apply compression to the urethra during activities that can cause urine leakage. For many women, pessaries are a low risk treatment option for pelvic organ prolapse (POP) or urinary incontinence. They allow you to be comfortable and active without surgery. About 85 percent of women can be successfully fit with a pessary regardless of age, medical history, or extent of prolapsed pelvic organs.

**Is a Pessary a Good Option for You?**
Consider wearing a pessary if you:

- Need temporary or long-term help with urine leakage during exercise.
- Have bothersome stress urinary incontinence (SUI) or POP symptoms and want a non-surgical treatment. Some women want to delay surgery and others want to avoid it completely—a pessary can help in both cases.
- Have health problems that make the risks of surgery too great.
- Are considering pregnancy in the future and need to postpone surgery until after you have completed your family.
- Take the time to remove, clean, and reinsert the pessary on a regular basis. This can be done by you at home or through regular visits to your health care provider.

**Learn the Terms**

- **Vaginal pessary**: A device usually made of medical-grade silicone inserted into the vagina to correct vaginal prolapse or treat urinary incontinence.
- **Pelvic organ prolapse (POP)**: Dropping of the pelvic organs, such as the bladder, uterus, and rectum, caused by a loss of vaginal support.

**Wearing a Pessary**
Pessaries require fitting. This fitting is easily done during an office visit, allowing you to leave the office with a properly fitted pessary.
Resources: Professional practice
Coding for Fitting and Insertion of a Pessary

A pessary is a device worn in the vagina for the treatment of pelvic organ prolapse or stress urinary incontinence. The pessary provides support of the vaginal walls or uterus when they have prolapsed by repositioning these organs to their original position. Some pessaries are specifically designed to stabilize the urethra for stress urinary incontinence. Pessaries can be used for short term or long-term treatment. They require long term surveillance for fit and for the health of the vaginal walls. Pessaries can also be used as a diagnostic tool to determine if symptoms are related to prolapse found on examination and to aide in therapeutic decision making.

Current CPT Codes for Reporting the Fitting and Insertion of a Pessary or Maintenance Procedures:
57160: Fitting and insertion of pessary or other intra-vaginal support device
57150: Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease

HCPCS Codes for Pessaries:
A4561: Pessary, rubber
A4562: Pessary, non-rubber
A4320: Irrigation tray with bulb or piston syringe, any purpose

CPT codes and RVU Table:

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References


References

References


References


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