NHS Tayside has now considered your request dated 9 July 2019

NHS Tayside wishes to advise you that there are exemptions applicable to the information requested. Please refer to the exemptions section of this correspondence.

Extract from Request

“We represent a group of multi-professional clinicians and pessary users who have come together following a recognised need for UK guidelines relating to pessary for prolapse management. To date, the UK lacks an evidence based guideline detailing various aspects of pessary care.

As a group, our long-term aims are:
To undertake a service evaluation to establish where and who delivers pessary care in the UK
Publish the findings of the service evaluation
Use data collected in the service evaluation to create a sampling frame of pessary practitioners
Distribute a clinician survey to pessary practitioners within the sampling frame to determine aspects of pessary practices across the UK
Publish the findings of the clinician survey
Undertake a consensus exercise to establish agreement between experts regarding pessary care
Formulate and publish guidelines for pessary care in the UK

We are writing to you and colleagues in Primary, Secondary and Tertiary care, with a freedom of information request to obtain the following data:
1)- How many new pessaries are inserted in your Trust/ CCG/ Practice in the last year?
2)- How many pessaries are changed in your Trust/ CCG/ Practice in the last year?
3)- What are the training requirements for a pessary practitioner in your Trust/ CCG/Practice?
   Please share any related competency or training documents
4)- Who provides pessary care in your Trust/ CCG/ Practice? “

Response

1. Information not held in the format requested but an estimated figure for “new patients and first trial of pessary is around 600.

   * new includes insertion of the first time pessary, not a replacement of the pessary with the new one.

2. Again, information not held in the format requested but 2000 per year is the estimated figure for number of pessaries **changed, both consultant’s and Nurse Pessary Clinics also Gynaecology Assessment Units in Perth Royal Infirmary and Ninewells Hospital.
**change of the pessary**- is the change with the new one or check up visit and
reinsertion of the same one.

3. Please see appended below NHS Tayside’s guidelines/advice and management of
pessaries.

   Appendix 1 - Guidelines for the Management of Patient with a Pessary at Nurse Clinic.
   Appendix 2 - Vaginal Pessary Advice
   Appendix 3 - Vaginal Pessary Management

4. Nurse Pessary Clinics, Consultants during GOPC, Urogynaecology Clinics,
   Gynaecology Assessment Unit, Local GP.

Exemptions Section – application of Freedom of Information (Scotland) Act 2002
exemptions and Data Protection Act 2018 Principles.

<table>
<thead>
<tr>
<th>Document Ref.</th>
<th>FOISA Exemption Applied</th>
<th>Justification</th>
</tr>
</thead>
<tbody>
<tr>
<td>IGTFOISA6502</td>
<td>Section 17 – Information not held, (Qs 1&amp;2)</td>
<td>NHS Tayside does not hold the information requested</td>
</tr>
</tbody>
</table>

Under section 20 (1) of the Act, if you are dissatisfied with the way NHS Tayside has dealt
with your request, you have a right to request a review of our actions and decisions in
relation to your request, and you have a right to appeal to the Scottish Information
Commission.

A request for an internal review must be made in writing no later than forty working
days from receipt of this response and sent to:

Head of Information Governance
Maryfield House (South)
30 Mains Loans
Dundee
DD4 7BT

Or by email to informationgovernance.tayside@nhs.net
If you are not content with the outcome of the internal review, you have the right to apply directly to the Scottish Information Commissioner for a decision. The Scottish Information Commissioner can be contacted at:

Scottish Information Commissioner
Kinburn Castle
Doubledykes Road
St Andrews, Fife
KY16 9DS

Or via the online appeal service: [www.itsspublicknowledge.info/Appeal](http://www.itsspublicknowledge.info/Appeal)

If you have any queries about this correspondence, please contact:

Information Governance Team
Maryfield House
30 Mains Loan
Dundee
DD4 7BT

Telephone - 01382 424413
E-mail: informationgovernance.tayside@nhs.net

Information Governance
NHS Tayside
30 July 2019
Tayside University Hospitals

<table>
<thead>
<tr>
<th>Women, Children &amp; Families Division.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynaecology Outpatients Department</td>
</tr>
<tr>
<td>Guidelines for The Management of Patient with a Pessary at Nurse Clinic</td>
</tr>
</tbody>
</table>

**Author:** SCN Elaine Coupar  
**Developed:** October 2006  
**Reviewed & Updated by:** D Brand Senior Nurse Gynaecology Services, NHS Tayside

**Last Review:** June 2019

**Next Update:** June 2021
CONTENTS

1. Context

2. Purpose and Scope

3. Statement of Guidelines:
   - Clinic Criteria
   - Criteria for Nursing Staff Undertaking Pessary Management
   - Staffing of Nurse Led Pessary Service
   - Medical Staff Support for Nurse Led Pessary Service
   - Algorithms and Protocols Supporting the Nurse Led Pessary Service
   - History Taking
   - Consent
   - Procedure for removal of Pessary, Perineal and Speculum Examination
     and Subsequent Reinsertion of Pessary Device / or appropriate follow up.
   - Documentation

4. Appendices:
   - Appendix 1, Protocol for the use of Vaginal Oestrogen in Patients with a Vaginal Pessary
   - Appendix 2, Pessary Protocols
   - Appendix 3, Algorithm 2: Management of Patient with Pessary and PV Bleeding
   - Appendix 4, Algorithm 1: Management of Patient with a Pessary at Nurse Led Clinic
1. Context:

The aim of the Nurse Pessary Clinic is to provide care to this group of Patients by a fully trained and competent individual.

2. Purpose and Scope:

The purpose of this document is to ensure that all staff (both Nursing and Medical) working within Gynaecology Department, are knowledgeable in the Management of the Patient with a Pessary at the Nurse Clinic. This will ensure a consistent approach to the management of the Patient with a pessary and ensure practice is safe and effective.

3. Statement of Guidelines:

Clinic Criteria:

- All Patients will have their initial pessary fitted by a member of the Medical Team.
- Patients with a correctly sized pessary can attend the Nurse clinic, only after a second consultation with a Medic to ensure pessary is the correct size.
- Consultant Gynaecologist or their deputy must refer Patient to the Nurse clinic.
- Nurse can refer Patient for medical review as required.
- All NHS Tayside Policies are adhered to.
- Nurse Led Pessary clinic will run alongside Consultant Led clinic; thus, a medical review is readily at hand.

Criteria for Nurse undertaking Pessary Management:

- A First Level Registered Nurse who has completed Management of Patients with a Pessary Clinical Skills Pack.
- Practitioner must be fully aware of the guidelines governing the Gynaecology Nurse Pessary Clinic.
- Nursing staff may request further training at any time to allow them to continue with this skill.

Staffing of Nurse Led Pessary Clinic Service:

Gynaecology Outpatient Services, Ninewells Hospital:
Senior Charge Nurse Lorna Donald
Women's Unit, PRI:
Senior Charge Nurse Jane Black

The clinic will run with nominal care of an Interested Consultants: Dr Kay, Dr Tkacz, Dr Christie, Dr Harvey and Dr Youssef
- 1 x 1st Level Registered Nurse with appropriate training
- 1 x Health Care Assistant
Medical Staff Support:

In the event that Patient same-day-review is required, the following steps are taken:

1. Approach Medical staff in Gynaecology Clinic

If unable to assist

2. Contact Registrar on call for Gynaecology Services on Pager Number 5610

Or

Telephone Gynaecology Assessment Unit, Ninewells Hospital on extension 32761
Algorithms and Protocols for The Nurse Led Pessary Clinic:

An Algorithm is a computable set of steps to achieve a desired goal.

The desired goal of this Algorithm is to facilitate the First Level Registered Nurse in his / her management of the Patient with a pessary, these Algorithms are supported by Guidelines outlined within this document:

- Algorithm 1: Management of Patient with a Pessary at Nurse Clinic
- Algorithm 2: Management of Patient with a Pessary and PV Bleeding
- Protocol for the use of Vaginal Oestrogen in Patients with a Vaginal Pessary
- Pessary Protocols

History Taking:

- History taking at the Nurse Led Pessary Clinic is a synopsis of the Patients account of her symptoms since her previous consultation. A carefully taken history provides a clinical guide to the physical examination to follow.

- The Nurse asks questions pertinent to the consultation. The Algorithm advises the Nurse how to proceed according to the Patients’ responses, examination and clinical findings.

Consent:

- The Nurse Led Pessary Clinic will utilise the same Verbal Consent format as used by Medical Staff in the Department, the name and signature of the Nurses Chaperone will also be documented in the Patients’ notes verifying verbal consent.
Procedures for:

Removal of Pessary, Vulval, Perineal & Speculum Examination and subsequent Reinsertion of Pessary / or appropriate follow up.

Preparation of the Patient:
- The patient should be given an explanation of the procedure.
- Verbal Consent obtained
- Allow the Patient privacy to undress, and position herself on the examination couch (assist if required).

Preparation of Equipment:
- Disposable gloves and apron
- Lubricant
- Disposable Speculum (various sizes)
- Lighting
- Prescribed Pessary Type and Size
- Sterile Pessary Introducer
- Tissue Paper
- Hand Wipes
- Sanitary Towels.

Removal of Pessary:
- The Nurse should wash hands and don apron and gloves
- Initial inspection of vagina is made
- The Nurse should insert index finger (coated in lubricant) of the dominant hand into the Patients’ vagina to locate the pessary (lying under the symphysis pubis)
- Gentle manipulation of the pessary is performed, ensuring that it is not adhered to the vaginal walls. Once this is ascertained the index finger is hooked underneath the pessary and is removed gently using a continual downward traction movement
- Inspect the pessary for signs of bleeding or discharge
- Discard as per Infection control Guidelines.

Vulval, Perineal and Speculum Examination:
- Inspect the Vulva and Perineum
- Assess the size of speculum to be used
- Apply lubricant to the speculum
- The examiner parts the labia and the speculum is applied to the vulva with the handles at an angle of 45° from the vertical (10 o’clock position). Insert gently downwards towards the hollow of the sacrum
- Care should be taken not to apply pressure against the urethra and anterior bony arch of the pubis
- Once fully inserted turn handles to a vertical position (12 o’clock) and gently open and hold in position with the cervix visualised between the blades
- A torch or lamp is required to ensure good light is directed into the vagina
- Inspection of the vagina and cervix can now be performed
- Microbiology / Cytology Swabs and / or a Cervical Smear can be performed if required
- To remove vaginal speculum, ensure cervix is clear of speculum, gently close speculum and ease out
- Inform Patient of findings.
<table>
<thead>
<tr>
<th>No Abnormality Detected</th>
<th>Fit new pessary of equal type and size.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal Discharge</td>
<td></td>
</tr>
<tr>
<td>Non-offensive Discharge:</td>
<td></td>
</tr>
<tr>
<td>• No High Vaginal Swab (HVS) required</td>
<td></td>
</tr>
<tr>
<td>• Fit new pessary of equal type and size</td>
<td></td>
</tr>
<tr>
<td>Offensive Discharge:</td>
<td></td>
</tr>
<tr>
<td>• Obtain HVS</td>
<td></td>
</tr>
<tr>
<td>• Fit new pessary of equal type and size</td>
<td></td>
</tr>
<tr>
<td>Patient aware / Symptomatic:</td>
<td></td>
</tr>
<tr>
<td>• Obtain HVS</td>
<td></td>
</tr>
<tr>
<td>• Fit new pessary of equal type and size</td>
<td></td>
</tr>
<tr>
<td>NB: All HVS Reports will be directed to GP for action, by the Nurse who obtained the HVS.</td>
<td></td>
</tr>
<tr>
<td>Erosion / Ulceration / Granulation</td>
<td>Initially:</td>
</tr>
<tr>
<td>Initially:</td>
<td></td>
</tr>
<tr>
<td>• Remove Pessary</td>
<td></td>
</tr>
<tr>
<td>• Advise use of Oestrogen Cream (as per Protocol) Appendix 1</td>
<td></td>
</tr>
<tr>
<td>• Review in 4 weeks at Nurse Led Clinic</td>
<td></td>
</tr>
<tr>
<td>4 Week Review:</td>
<td></td>
</tr>
<tr>
<td>• <strong>If healthy</strong>, fit new pessary of equal type and size</td>
<td></td>
</tr>
<tr>
<td>• <strong>If no change</strong>, Medical Review required</td>
<td></td>
</tr>
<tr>
<td>Vaginal Bleeding</td>
<td>As Algorithm 2, Appendix 3.</td>
</tr>
<tr>
<td>Cervical Smear</td>
<td>Obtained by competent Cervical Smear taker.</td>
</tr>
<tr>
<td>Any other concerns</td>
<td>Medical Review required.</td>
</tr>
</tbody>
</table>

**Proceed as per Algorithm 1, Appendix 4:**

Reinsertion of Pessary:

- Prepare the pessary for insertion by applying lubricant to the pessary introducer if required
- Put the Pessary into the introducer if required, until approximately halfway
- Holding the primed introducer if required in dominant hand, part the labia
- Insert the introducer, if required, primed with the pessary into the vagina
- Use the thumb of the dominant hand to push the pessary free from the introducer
- The pessary is now in the vagina and the introducer if used can be disposed of in the appropriate manner
- Manipulate pessary into place. When the pessary is properly placed, the cervix will be supported by the diaphragm with the pessary sitting in the posterior vaginal fornix
- The Patient is asked if the pessary feels comfortable whilst in the supine position
- The Patient is asked to stand. In the standing position the Patient is asked to cough and to walk around the examining room. Fitting is judged successful if the Patient does not feel the pessary coming down and she feels comfortable
- With the procedure completed the Patient can redress. Patient is offered tissues, hand wipes and a sanitary towel if required, (assist if required)
- Dispose of equipment as per Infection Control Guidelines
- The Nurse washes their hands
- Inform Patient and proceed as per Algorithm.
Follow Up Arrangements:

Follow up arrangements are made prior to the Patient leaving the Clinic.

<table>
<thead>
<tr>
<th>Algorithm Ends:</th>
<th>Follow up will be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fit New Pessary of equal Type</td>
<td>For the Patient whose Algorithm ends</td>
</tr>
<tr>
<td>and Size</td>
<td>on the fitting of new pessary of equal type and size:</td>
</tr>
<tr>
<td></td>
<td>• A 6 month follow up appointment at the Nurse Led Clinic is issued.</td>
</tr>
<tr>
<td>Medical Review</td>
<td>For the Patient requiring Medical</td>
</tr>
<tr>
<td></td>
<td>Review, the appropriate follow up is made as requested by the Physician.</td>
</tr>
<tr>
<td>PMB Clinic Review</td>
<td>For the Patient requiring PMB Clinic review:</td>
</tr>
<tr>
<td></td>
<td>• The Nurse adds Patient onto</td>
</tr>
<tr>
<td></td>
<td>appropriate PMB Clinic slot</td>
</tr>
<tr>
<td></td>
<td>• Patient issued with appointment letter and relevant Patient Information</td>
</tr>
<tr>
<td></td>
<td>Leaflet.</td>
</tr>
<tr>
<td>Ultrasound Scan and Review</td>
<td>In the event that a timely PMB Clinic slot cannot be allocated:</td>
</tr>
<tr>
<td></td>
<td>• The nurse arranges an urgent Ultrasound Scan in the Department of Ultrasound.</td>
</tr>
<tr>
<td></td>
<td>• The Nurse is responsible for ensuring any ultrasound scan findings and</td>
</tr>
<tr>
<td></td>
<td>follow up arrangements are communicated to the Patient.</td>
</tr>
</tbody>
</table>

Documentation:

<table>
<thead>
<tr>
<th>Document:</th>
<th>Procedure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Notes / Outcome Document</td>
<td>• Enter details of consultation</td>
</tr>
<tr>
<td></td>
<td>• Complete Outcome Document noting</td>
</tr>
<tr>
<td></td>
<td>follow up and procedures undertaken</td>
</tr>
<tr>
<td>Information / Advice Leaflet</td>
<td>• Issue to every Patient at end of</td>
</tr>
<tr>
<td></td>
<td>procedure</td>
</tr>
<tr>
<td></td>
<td>• Help Line contact details given.</td>
</tr>
<tr>
<td>Letters: General Practitioner</td>
<td>• Via digital dictation</td>
</tr>
<tr>
<td>Patients Medical Notes</td>
<td></td>
</tr>
</tbody>
</table>


Appendices:

- Appendix 1, Protocol for the use of Vaginal Oestrogen in Patients with a Vaginal Pessary
- Appendix 2, Pessary Protocols
- Appendix 3, Algorithm 2: Management of Patient with Pessary and PV Bleeding
- Appendix 4, Algorithm 1: Management of Patient with a Pessary at Nurse Led Clinic
APPENDIX 1

Protocol for use of Vaginal Oestrogen in Patients with a Vaginal Pessary

If vaginal oestrogen is required, please prescribe nightly dose for 2 weeks, then alternate nights for 2 weeks and then twice weekly for 4-6 months – Vagifem pessaries or Orthogynest cream.

Asymptomatic Patients with normal vaginal mucosa
(No PVB, healthy mucosa)

With the patient who has no bleeding and, on removal of the pessary, the vaginal walls are healthy, vaginal oestrogen is not required.

Asymptomatic Patient’s with superficial ulceration of vaginal mucosa
(No PVB, bleeding at removal)

With the Patient who has no bleeding since last pessary insertion BUT on removal of the pessary, the vaginal walls are superficially ulcerated, oestrogen may be required (see contraindications). Treatment as above. In the presence of mild ulceration with minimal or no bleeding the pessary can be replaced. If ulceration is more extensive or contact bleeding has been precipitated by pessary removal then the pessary should not be replaced until review at 4 to 6 weeks.

Symptomatic Patients
(Patients with PVB while pessary in place) – see flow chart

A Patient who complains of bleeding whilst their pessary is in situ may require further investigation prior to treatment. All patients will need the pessary to be removed; the vaginal mucosa to be inspected for any suspicious appearance and the pessary left out for 4 to 6 weeks.

If the patient still has a uterus or cervix further investigation with transvaginal ultrasound is required. An endometrial thickness of >3mm will require an endometrial biopsy to identify any malignancies or hyperplasia. An endometrial thickness of <= 3mm does not require a biopsy and vaginal oestrogen may be started as above.

Oestrogen therapy should not be commenced until results available.

An ultrasound scan may be performed immediately in clinic if a suitably trained member of staff is available to do so. If no-one is available;

**Option 1.** A Patient should only be given an urgent PMB slot if the vaginal walls do not look ulcerated or blood is seen coming through the cervical os.

**Option 2.** If local causes seen eg atrophy or erosion, then the next available slot (within 2 weeks) should be booked in the Gynaecology Ultrasound Department.

If the Patient has had a total hysterectomy (no uterus or cervix) and the vaginal vault is eroded / ulcerated but not suspicious, then vaginal oestrogen can be commenced immediately as above and the pessary left out for 4 to 6 weeks.
Any suspicious appearances on examination, or abnormal findings on scan, should be seen by the Registrar or Consultant responsible for that patient.

**Type of oestrogen**

The oestrogen used will depend upon the preference of the Patient and the frequency of use. Vagifem is licensed for long term use as required so should be used as first line for Patients with a pessary as it is likely that they will require vaginal oestrogen from time to time for the long term. Orthogynest cream may be used as an alternative but if use is frequent then Vagifem should again be discussed with the Patient. In studies Vagifem did not lead to endometrial thickening over 2 years of continuous use. The equivalent data for Orthogynest is not available.

**Contraindications to oestrogen use**

- Current or history of oestrogen dependent tumour
- Undiagnosed vaginal bleeding
- Thrombo-embolism
- Arterial disease
- Abnormal LFTs
## APPENDIX 2

### Pessary Protocols

<table>
<thead>
<tr>
<th>Type of Pessary</th>
<th>Portex Ring Pessary</th>
</tr>
</thead>
</table>
| **Indication / s** | - 1st line device  
- Suitable if sexually active  
- Used for management of 1-2nd degree prolapse |
| **Initial Care** | - Fit in Clinic  
- Provide Patient Information, completing details of pessary fitted |
| **Replacement** | Replace Portex Ring 6 monthly. |
| **Initial Follow-up** | - In 6 months at a Medical Clinic until correct size fitted / Patient happy with pessary  
- Agree plan with Patient and document long term management plan |
| **Long-term Follow-up** | - At 6 monthly Nurse Led Clinic, but Patient to remain under care of Consultant. Patient can be referred back to named Consultant if any problems |

<table>
<thead>
<tr>
<th>Type of Pessary</th>
<th>Folding Ring Pessary</th>
</tr>
</thead>
</table>
| **Indication / s** | - Suitable for Patients with a narrow Interiotus  
- Uncomfortable during insertion / removal of Portex Ring Pessary  
- Patient able to self-manage pessary  
- Used for management of 1-2nd degree prolapse |
| **Initial Care** | - Wash in water (to remove powder)  
- Dry prior to fitting  
- Fit in clinic  
- Provide Patient Information, completing details of pessary fitted |
| **Replacement** | Wash at each change (every 6 months) and replace every 10 years. |
| **Initial Follow-up** | - At 4-6 months Medical Clinic until Patient happy / correct size fitted  
- Consider training Patient to insert and remove themselves  
- Agree plan with Patient and document long term management plan |
| **Long-term Follow-up** | **Non-self-Management:**  
- A 6 monthly Nurse Led Clinic, but to remain under care of Consultant. Patient can be referred back to named Consultant if any problems  
**Self-Management:**  
- Self-insert and remove pessary  
- Patient can be discharged after review appointment. If this is the case, open appointment to be provided for 1 year so Patient can request review if required  
- Agree plan with Patient and document long term management plan |
<table>
<thead>
<tr>
<th>Type of Pessary</th>
<th>Cube Pessary</th>
</tr>
</thead>
</table>
| **Indication/s** | • Suitable if sexually active  
• Suitable if prolapse descends below / through other pessaries  
• Used for management of 1-4\textsuperscript{th} degree prolapse  
• Patient able to self-manage pessary |
| **Initial Care** | • Wash in water (to remove powder)  
• Dry prior to fitting  
• Fit in clinic  
• Provide Patient Information, completing details of pessary fitted  
• Teach patient how to self-insert and remove pessary, can be discharged after Nurse appointment  
• Agree plan with Patient and document long term management plan |
| **Replacement** | • At 4-6 months Medical Clinic until Patient happy / correct size fitted  
• Consider training Patient to insert and remove pessary themselves  
• Agree plan with Patient and document long term management plan  
**If Self-Management:**  
• Provide spare pessary  
Replace Cube Pessary every 10 years. |
| **Initial follow-up** | Agree plan with Patient and document long term management plan. |
| **Long-term follow-up** | **Non-self-Management:**  
• Monthly Nurse Led Clinic. Patient to remain under care of Consultant and can be referred back to named Consultant if any problems  
**Self-Management:**  
• Self-insert and remove pessary. Patient can be discharged after review appointment, but provide open appointment for 1 year so Patient can request review if required  
• Agree plan with Patient and document long term management plan |
<table>
<thead>
<tr>
<th>Type of Pessary</th>
<th>Gellhorn Pessary / Milex Shaatz</th>
</tr>
</thead>
</table>
| **Indication / s** | • 2<sup>nd</sup> line device when Ring Pessary not successful  
• Not suitable if sexually active  
• Suitable for management of 3<sup>rd</sup>-4<sup>th</sup> degree prolapse |
| **Initial Care** | • Wash in water (to remove powder)  
• Dry prior to fitting  
• Fit in Clinic (consider if require long, short or no stem depending on vaginal length)  
• Provide Patient Information, completing details of pessary fitted |
| **Replacement** | • Wash at each 6 monthly change  
• Replace every 10 years |
| **Initial Follow-up** | • At 6 months Medical Clinic until Patient happy / correct size fitted  
• Agree plan with Patient and document long term management plan |
| **Long-term Follow-up** | • 6 monthly Nurse Led Clinic. Patient to remain under care of Consultant and can be referred to named Consultant if any problems  
(Ideally remove pessary, examine vagina and replace at each appointment. If Patient is very uncomfortable pessary can be rotated / manipulated to free vaginal tissue).  
Replace Pessary annually. |

<table>
<thead>
<tr>
<th>Type of Pessary</th>
<th>Shelf / Popy Pessary</th>
</tr>
</thead>
</table>
| **Indication / s** | • 2<sup>nd</sup>/3<sup>rd</sup> line device when Ring / Gellhorn Pessary not successful  
• Not suitable if sexually active  
• Suitable for management of 3<sup>rd</sup>-4<sup>th</sup> degree prolapse  
Consider Popy Pessary if erosion with Shelf Pessary. |
| **Initial Care** | Fit in Clinic. |
| **Replacement** | Wash at 6 months and replace every 10 years. |
| **Initial Follow-up** | • At 6 months Medical Clinic until Patient happy / correct size fitted  
• Agree plan with Patient and document long term management plan |
| **Long-term Follow-up** | • At 6 monthly Medical Clinic  
(Ideally remove pessary, examine vagina and replace at each appointment. If Patient is very uncomfortable pessary can be rotated / manipulated to free vaginal tissue).  
Replace Pessary annually. |
<table>
<thead>
<tr>
<th>Type of Pessary</th>
<th>Donut Pessary</th>
</tr>
</thead>
</table>
| **Indication** / s | • 2nd line device when Ring Pessary / Gellhorn / Shelf not successful  
• If prolapse decent below / through other pessaries  
• Not suitable if sexually active  
• Suitable for management of 3rd-4th degree prolapse |
| **Initial Care** | • Wash in water (to remove powder)  
• Dry prior to fitting  
• Fit in clinic  
• Provide Patient Information, completing details of pessary fitted |
| **Replacement** | Wash at 6 months and replace annually. |
| **Initial Follow-up** | • At 6 months Medical Clinic until Patient happy / correct size fitted  
• Agree plan with Patient and document long term management plan |
| **Long-term Follow-up** | • At 6 monthly Nurse Led Clinic. Patient to remain under care of Consultant and can be referred back to named Consultant if any problems |
Management of Patient with Pessary and PV Bleeding

For patients reporting episodes of vaginal bleeding, an in-depth history of the bleeding is required inclusive of:

- Number of episodes
- How often they have occurred
- How heavy the episodes are etc

Algorithm 1: Algorithm for Patient with a Pessary and PV Bleeding

PV Bleeding

Remove Pessary

Vaginal / Perineal / Speculum Examination

No Abnormalities Detected

Post menopausal woman with uterus

Leave Pessary out.

Refer as per woman with PMB.

i.e. Option 1: Issue with PMB clinic appointment.

OR

Option 2: Nurse organises an URGENT ultrasound scan and GOPD review.

Scan Request Form:

PMB ET & Ovaries


Algorithm 2: Management of Patient with Pessary at Nurse Clinic

1. Obtain Patient History
2. Inform patient of procedure and obtain consent
3. Afford patient privacy to undress and position herself on the examination couch (assist if required).
4. Remove pessary, assess the type and size of speculum that you require
5. Vulval/Perineal & Speculum Examination
6. Any other concerns, E.g. cervical abnormality
    - Medical Review
7. Vaginal Bleeding
    - Refer Algorithm 2: Ring Pessary Patient with Vaginal Bleeding
8. No Abnormality Detected.
    - (Routine Cervical Smear if appropriate)
9. Offensive Vaginal Discharge/Erosion/Ulceration/Granulation
    - 1 Remove Ring
    - 2 Refer to Vaginal Oestrogen Protocol
    - 3 Review at Nurse Clinic in 4-6 weeks
10. Healthy
    - Fit new ring of equal size
11. Discharge not changed: HVS GOPD Consultant review 6 weeks

Ensure patient is comfortable after procedure assist if necessary

Record Details in notes, on Data-base and generate appropriate letter/s.

Arrange routine 6monthly follow up, or as requested by medical staff

END
Vaginal Pessary Advice

Patient Information

Type of Pessary: .................................................................

Date inserted:.................................................................

Pessary inserted by: ..........................................................

The aim of this leaflet is to help you understand more about your prolapse and how using a vaginal pessary may help.

What is a Prolapse?
A prolapse is when the uterus or vagina comes down from its normal position in the pelvic cavity into the vaginal canal. It is caused by relaxation of the supporting structures of the pelvic floor.
There are several different types of prolapse and symptoms depend on the type of problem. The usual symptoms include a feeling of 'something coming down', recurrent urinary tract infections, trouble emptying your bladder or bowels, discomfort with sexual intercourse and chaffing.

What can I do to improve the symptoms?
The symptoms of prolapse can be improved by reducing the pressure on the pelvic floor or strengthening the pelvic floor muscles.

This may be achieved by:
- Lose weight if overweight
- Stop smoking
- Avoiding constipation by increasing your fibre and fluid intake
- Regular pelvic floor exercises
- Avoid heavy lifting

What is a vaginal pessary?
Your doctor has recommended treatment with a vaginal pessary. This is a small device which is inserted into the vagina to hold the prolapse in place. Pessaries are made of silicone or acrylic and come in many different shapes and sizes. Ring pessaries are the most common, but may not be right for every woman. Your doctor will discuss with you which pessary is the most suitable treatment.
Benefits of a vaginal pessary include:

- Relief of pressure symptoms
- Make it easier to empty the bladder
- Relief of problems emptying the bowels
- Control of the deterioration of your prolapse

A com placation of a vaginal pessary is ulceration of the vaginal wall. This causes discomfort and a blood stained discharge. The pessary will be removed for 2 – 4 weeks to allow the vagina to heal.

What happens next?
The doctor will examine you internally through your vagina to decide on the type and estimate the size of the pessary. It can sometimes take a few times to get the correct fit. After fitting your pessary, you will be asked to walk around, sit, squat, cough and strain to test if it is comfortable and remains in place. Please tell the doctor if it doesn’t feel right, even if it is the second, third or fourth pessary you have tried. Some pessaries are designed to be removed by the woman. You may be given advice on how to remove and insert your pessary.

If the vaginal pessary falls out or causes you any problems do not worry, just call the helpline number and we will arrange a return appointment for you.

Helpline Number:
You will find the contact details for the clinic you attended on the back of this leaflet, call this number in the first instance.

What happens after I have a pessary fitted?
Once you have found the best fit, you will be given a return appointment to be seen at the nurse clinic. This is to check the pessary is suiting you. The nurse will examine you vaginally and the pessary may be removed and cleaned. Further follow up appointments will be arranged usually at 6 month intervals. An early appointment may be arranged if there are any problems.

Commonly asked questions

I have a discharge is this normal?
Vaginal discharge is often increased by the presence of a pessary, but it should not smell offensive or be blood stained. If you experience either of these symptoms then phone the helpline for advice.

I have bleeding and I am worried. Is this normal?
This may or may not be due to the pessary. This should always be investigated by phoning the helpline for advice. You may either be advised to see your GP first or we will arrange to see you at the clinic.
What if I have any discomfort?
Once the pessary is fitted correctly you should be unaware it is there. However it can move if you strain to move your bowels or with heavy lifting. If this occurs you can try inserting a finger into the vagina and see if you can move the pessary into place or you can phone the helpline for advice. If you are in severe pain, you should phone the helpline.

What if I am in pain?
It is not normal to have pain with a vaginal pessary. Initially you may have slight discomfort after insertion. If you are in severe pain you must seek prompt assistance, either by phoning the helpline, your GP or NHS 24 for advice.

Can I have sexual intercourse whilst using a vaginal pessary?
Some pessaries may interfere with sexual intercourse. A ring pessary may be left in place during sex but other pessaries may literally get in the way. Some pessaries can be removed before sexual intercourse, such as a cube pessary. Your doctor will discuss this with you, but if you are unsure, please ask.

What if I have urinary problems?
Often a vaginal pessary will improve urinary symptoms. Rarely, you may find the pessary causes difficulty in urinating or urinary incontinence. If you experience either of these symptoms, phone the helpline for advice.

What happens if the vaginal pessary does not work?
Vaginal pessaries do not work for all women. You may decide that the symptoms are mild and that no other treatment is needed. Your doctor may discuss the option of a prolapse operation.

Should you have any problems with your pessary between now and your next appointment, please do not hesitate to contact us on the helpline.

Useful information
Please find below three links to other patient information sheets that you may find useful.

http://bsug.org.uk/patient-information.php
http://www.iuga.org/?page=patientinfo

Contact numbers:

Ninewells Hospital
Gynaecology Outpatient Department
Telephone: 01382 633864

Perth Royal Infirmary
Gynaecology Ward
Telephone: 01738 473426
Arbroath Infirmary
Nurse Office Outpatient Department
Telephone: 01241 0822547

Whitehills Health and Community Care Centre, Forfar
Appointments Secretary Arbroath
Telephone: 01241 822528

Links Health Centre, Montrose
Outpatient Reception
Telephone: 01674 817192

Developed and reviewed by Gynaecology staff and patients
Revised: 06/2017  Review: 06/2019  LN0235
Clinical Skills Programme
Vaginal Pessary Management

Developed by:
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Gynaecology Outpatient Department
Ninewells Hospital
Date Developed: August 2013
Reviewed & Updated by:
D Brand, Senior Nurse
Clinical Skills Programme
Management of the Patient with a Vaginal Pessary
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7. Flow Chart Facilitating Pessary Telephone Calls to Area 3, Ninewells Hospital and Women’s Unit, PRI
8. Protocol for use of Vaginal Oestrogen in Patients with a Vaginal Pessary
9. Vaginal Pessary Advice, Patient Information Leaflet
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Dr Tkacz (Consultant Gynaecologist & Obstetrician)
Dr Christie (Consultant Gynaecologist & Obstetrician)
Dr S Harvey (Consultant Gynaecologist)

This package will be reviewed by the author or deputy and an interested Gynaecologist two yearly, or if new practices come into play.
Management of Patient with a Vaginal Pessary

Section 1
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1:1 Rationale for Programme

This programme has been developed to provide knowledge to professionals regarding the management of patients with vaginal pessaries.

This document contains theoretical information to enable practitioners to enhance their knowledge, identify good practice and enable effective, safe, clinical care. Learning outcomes are provided together with a self-assessment of core knowledge skills.

An essential requisite for the programme is that the learner has access to and is familiar with NMC The Code: Professional standards of practice and behaviours for nurses, midwives and nursing associates (2018) available at https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf and doctors: /www.gmc-uk.org/guidance/

It is advisable to have knowledge of the Women, Children & Families Clinical Care Group, Women’s Reproductive Health and Guidelines for Vaginal Speculum Examination and Swab Taking, 2016.
1:2 How to use this Programme

Prerequisites:
It is essential that the practitioner has knowledge and understanding of the structure of the pelvic floor.

This clinical skills pack is a self-directed programme, with practical learning and competencies to be achieved in the management of the patient with a pessary.

Supervision and assessment of your practice, within the clinical area by a competent practitioner is required. Successful completion of this component will be achieved when:

- The theoretical programme has been completed
- The theoretical assessment is successfully completed
- The practical competencies have been achieved

Throughout the text, activities are provided which will encourage the use of reflective, decision making, observational and cognitive skills. Discussion of theses activities with your assessor will provide evidence of learning underpinning knowledge of the theoretical content of this clinical skills package.

You are encouraged to return to the text, or the literature outlined in the reference list if you are unable to answer any of the questions or activities.

It is anticipated that the self-study component of this guide should be completed within an 8-week period, if this is not possible time should be negotiated with your Line Manager or Supervisor.

Practitioners should ensure they have the necessary knowledge, attitudes, values and skills required before using these skills in clinical practice. Supervised practice should be negotiated with your Line Manager.
1.3 Practitioner Responsibilities

- Each practitioner has a responsibility to integrate this skill into their practice for the benefit of patients in their care. If the clinical skill is not being used regularly, an update will be required before continuing to practice this skill.

- On successful completion of the Programme, each registered practitioner will be accountable and responsible for maintaining his or her own practice.

- Completed records for Nursing Staff training will be held within the clinical area by the Senior Charge Nurse. You should retain a copy in your personal records.

- The practitioner can utilise their skills across NHS Tayside, the practitioner should retain the package and record of completion as evidence.

- Practitioners, previously employed by other Health Boards, who have integrated the skill into their practice, will be required to complete the study pack comparing / benchmarking previous training / education / practice against standards set in this document and demonstrate competency in the skill.

Assessment includes:

- A self-assessment questionnaire focusing on the structure of the pelvic floor. You will be required to undertake further reading from the reference and bibliography lists to complete the activities and theoretical assessment.

- Additional reading from the reference and bibliography lists to compare the activities and theoretical assessment.

- Observe practical clinical demonstrations. Activities are included throughout the pack to facilitate critical review of current practice in relation to best practice identified in the learning package and demonstrated at the practical session.

- A period of supervised practice and assessment until the practitioner is competent in the skills associated with the management of the patient with a pessary. Your Assessor will evaluate your practice against the assessment criteria in this document.

Criteria for role as an Assessor

An Assessor is a Nurse practitioner who has completed this training previously and has been identified as suitable by the Clinical Lead for Gynaecology or a UroGynaecology Consultant and the Senior Nurse for Gynaecology Services.
1:4 Best Practice Statements

Throughout the package best practice statements have been developed to highlight clearly the key areas of practice relating to the management of the patient with a vaginal pessary. The aim of the best practice statements is to promote a consistent approach to the management of the patient with a vaginal pessary. They include the rationale for the best practice statements, the supporting evidence and a descriptor outlining the source of evidence. The best practice statements are derived from the best available evidence at the time they were produced.
1:5 Criteria for undertaking this Programme

On completion, each registered practitioner will be accountable and responsible for maintaining his/her own practice (NMC 2018, GMC: Intimate examination and chaperones 2015).


Competency will be discussed; completion of the programme will entail:

- Completion of the assessment involving self-assessment of core knowledge skills in the management of the women with a vaginal pessary
- Completion of clinical competencies
- Completion of this self-directed programme within an 8 week period
- Undertake a period of supervised practice. A **minimum of 10** supervised practice sessions relating to Ring Pessaries and **minimum of 3** supervised practice sessions relating to Popy Shelf, Cube, Melix Shaatz, Gehorn and Donut Pessaries must be carried out
- Any action plans / learning contracts should be noted within the pack
1:6 Learning Outcomes

On completion of this programme, the practitioner will be able to:

**Discuss their role in the management of the woman with a vaginal pessary, in relation to:**
- Medico-legal aspects
- Risk management
- Technical / clinical elements

**Assess by:**
- Demonstrating an understanding of the female pelvic anatomy
- Identify normal and abnormal changes in the vagina and cervix.
- Identify potential problems associated with vaginal pessary management

**Plan by:**
- Explain the methods used to gauge the correct size of vaginal pessary required
- Selecting the appropriate equipment required
- Identifying risk factors associated with pessary management
- Summarising the procedure of pessary management.

**Implement the management of a patient with a vaginal pessary by:**
Demonstrating the correct technique/procedure for:
- Completing history taking and appropriate documentation
- Preparing the patient for the procedure
- Demonstrating the removal of a pessary
- Performing speculum examination and assessing vagina
- Inserting pessary
- Arranging appropriate follow up and completing documentation
- Disposal of Equipment

**Evaluate process by:**
Analysing any difficulties, which may have occurred and reporting near misses relating to adverse incidents.
1:7 Medico Legal Aspects

As stated in section 1:1 an essential requisite for the programme is that the learner has access to and is familiar with the NMC The Code: Professional standards of practice and behaviours for nurses, midwives and nursing associates (2018) available at https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf and doctors: /www.gmc-uk.org/guidance/.
1:8 Practical Session

Before performing vaginal examination on patients, the practitioner must have obtained the required skills on a model. This will include a bimanual vaginal examination, speculum examination on a plastic pelvic model.

*Dr Kay can arrange individual sessions on request.*
Management of Patient a Vaginal Pessary
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Section 2

2:1  Normal Female Pelvic Anatomy

2:2  Abnormal Changes in the Vagina and Cervix (relevant to Vaginal Pessary Management) and types of Prolapse

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2:5  Nurses Role and Responsibility in Vaginal Pessary Management

2:6  Infection Control Aspects of Vaginal Pessary Management.
2:1 Normal Female Pelvic Anatomy

“It is essential that the practitioner can demonstrate knowledge of the relevant anatomy and physiology.”

Activity:


Extract (page 644) Anatomy of the Pelvic Floor

“ The pelvic floor consists of muscular and fascial structures that provide support to the pelvic viscera and the external openings of the vagina, urethra and rectum. The uterus and vagina are suspended from the pelvic side walls by endopelvic fascial attachments that support the vagina at three levels.”

... reflect and assess your knowledge by completing the following Self Assessment Questions.
SELF ASSESSMENT

1) THE PELVIC FLOOR

Question 1a
While the bony pelvis offers protection to the organs it encloses, it can by no means support them unaided. The pelvis and the ligaments make a framework where muscles can originate and insert. The muscles and ligaments of the pelvis are:

1. 

2. 

3. 

4. 

5. 

6. 

Question 1b
The outlet of the bony pelvis is filled with soft tissues which support the pelvic and abdominal organs. These tissues form not only a flat floor but a gutter-shaped structure which is higher posteriorly than anteriorly. Three canals, each with an external orifice. Run through the tissues: the urethra, the vagina and the rectum.

There are six layers of tissue:
1. An outer covering of skin.
2. Subcutaneous fat.
3. Superficial muscles enclosed in fascia.
5. Pelvic fascia thickened to form pelvic ligaments.
6. Peritoneum.

Can you use the diagram below to identify the areas indicated?

![Diagram of the pelvic floor with arrows pointing to specific areas.](image-url)
2) SUPERFICIAL PELVIC FLOOR MUSCLES

These muscles are of less importance than the levator ani muscles which lie above them but, they provide additional strength to the deep musculature by their support.

Remember these are the muscles that are normally traumatised during an episiotomy or a perineal tear.

*Question 2a*
Name the four muscles that are involved:
1. 
2. 
3. 
4. 

*Question 2b*
Using the diagram below, can you identify these muscles and surrounding structures?
**Question 2c**
Can you complete the following?

The blood supply is through branches of the . . . . . . . . . . and . . . .

The nerve supply is from the 3rd and 4th segments of the . . . . . and the. . . .

**3) DEEP PELVIC FLOOR MUSCLES**

These lie at a deeper level in the pelvis and above the superficial layer. They are about 5mm in depth. They each have their insertion around the coccyx and are therefore sometimes called the coccygeal muscles.

**Question 3a**
These muscles, although aided by the superficial layer, are of vital importance in the voluntary control of the . . . . and . . . .

There are three pairs of muscles which make up each levator ani muscle.

**Question 3b**
Using the diagram below, can you identify the three pairs of muscles and the surrounding structures?
**Question 3c**  
Can you complete the missing words?

Blood supply is from the . . . . . . . . . . . . . . . , branches of the . . . . . . . artery. Venous drainage is into the corresponding veins.

The nerve supply is from the . . . . . . . and . . . . . . .

The 5th sacral nerve and the coccygeal nerve pass through but do not serve these muscles.

**4) THE PERINEAL BODY**

The function of the perineal body is to assist in the process of defaecation and childbirth. During the latter function, the structure may become overstretched or torn. Trauma may result in disorders of micturition, bowel function and in prolapse of the pelvic organs.

Time to assess your knowledge base in relation to the Perineal Body.

**Question 4a**  
The Perineal Body lies between the . . . . . . . and . . . . . . . canals.

**Question 4b**  
Is the shape of the Perineal Body  
*(please circle answer)*

- Rectangular
- Circular
- Triangular

**Question 4c**  
Each side of the Perineal Body measures approximately  
*(please circle answer)*

- 3.5 cm in length
- 6.5 cm in length
- 10.5 cm in length
- 4.5 cm in length

**Question 4d**  
Can you identify the three layers of tissue which make up the structure of the Perineal Body?  
1)  
2)  
3)
**Question 4e**
Can you label the diagram below?

![Diagram of Perineal Body](image)

- The blood supply is from the pudendal arteries, branches of the internal iliac artery.
- Venous drainage is into the corresponding veins.
- The nerve supply is from the perineal branch of the pudendal nerve.

**Perineal Body**

---

**5) THE VULVA**

The external organs of the female are known collectively as the vulva.

**Question 5a**
Can you complete this diagram?
ANSWERS

1) THE PELVIC FLOOR

Question 1a
1. Sacrospinous Ligament
2. Sacrotuberous Ligament
3. Piriformis Muscle
4. Gluteus Maximus Muscle
5. Obturator Internus Muscle
6. White Line of Fascia

Question 1b

![Diagram of pelvic floor]

2) Superficial Pelvic Floor Muscles

Question 2a
1. Transverse Perinei Muscle
2. Bulbocavernosus Muscle
3. Ischiocavernosus Muscle
4. External Anal Sphincter
Question 2b

"The blood supply is through branches of the INTERNAL ILLIAC ARTERY and VEINS. The nerve supply is from the 3rd and 4th segments of the SACRAL PLEXUS and PUNDAL NERVE".

3) DEEP PELVIC FLOOR MUSCLES

Question 3a

"These muscles, although aided by the superficial layer, are of vital importance in the voluntary control of the BLADDER and BOWELS".

Question 3b
**Question 3c**
Blood supply is from the **PUDENDAL ARTERIES**, branches of the **INTERNAL ILIAC** artery. Venous drainage is into the corresponding veins.

The nerve supply is from the **3RD and 4TH SACRAL NERVES**.

**4) THE PERINEAL BODY**

**Question 4a**
Vaginal and Rectal.

**Question 4b**
Triangular

**Question 4c**
3.5 cms

**Question 4d**
1) Outer covering of skin.
2) Superficial Pelvic Floor Muscles i.e. Bulbocavernosus and Transverse perinei. Deep Pelvic Floor Muscle i.e. Pubococcygeus.

**Question 4e**

![Diagram of the perineal body](image-url)
5) VULVA

Question 5a
2:2 Abnormal Changes in the Vagina and Cervix
(relevant to Vaginal Pessary Management)
and types of Prolapse

"The Gynaecology Nurses practice must be based on a sound knowledge of anatomy, physiology and pathology of the female genital tract married to this a firm understanding of disease and abnormalities associated with the female genital tract is essential."

Activity: Describe the following disease / abnormalities of the Vulva and Perineum; keep a log of any of the abnormalities/diseases you observe in the clinical setting.

- Vulval dystrophy
- Leukoplakia
- Lichen sclerosus
- Benign neoplasms of the vulva
- Carcinoma of the vulva
- Warts
- Diseases of the urethra:
  - Caruncle
  - Urethra maetitis
  - Prolapse of the urethral mucosa
  - Cyst of skene’s duct
  - Urethrocele
  - Carcinoma
**Activity:** Describe the following disease / abnormalities of the Vagina; keep a log of any of the abnormalities / diseases you observe in the clinical setting.

- Vaginal discharge
- Cysts of the vagina
- Carcinoma of the vagina
Activity: Describe the following disease / abnormalities of the Cervix; keep a log of any of the abnormalities / diseases you observe in the clinical setting.

- Cervical ectropian
- Cervical polyps
- Chronic cervicitis
- Carcinoma of uterine cervix
Activity: discuss the following:

- The aetiology of prolapse
- The symptoms of prolapse
- The diagnosis of prolapse
- Urethrocele
- Cystocele
- Rectocele
- Enterocele
- Degrees of uterine prolapse

... maintain a record of the types of prolapse you observe in the clinical setting.
**Activity:** Discuss the effects the symptoms of prolapse can have. Reflect on how these symptoms could interfere with the individuals’ activities of living?
2:3 Management of Prolapse:

- Surgical Management
- Conservative Management

The following sections:


*Read the patient information sheets on prolapse surgery on the following link:* [http://www.iuga.org/?page=patientinfo](http://www.iuga.org/?page=patientinfo)

**A Prolapse: surgical management; anterior and posterior compartments.**

Surgery offers definitive treatment of prolapse. The choice of procedure depends on the patient and the type of prolapse that exists.

**Anterior compartment defect:**

**Anterior colporrhaphy (anterior repair):**

- Appropriate for the repair of a cysto-urethrocele
- A longitudinal incision is made on the anterior vaginal wall and the vaginal skin is separated by dissection from the pubocervical fascia
- Buttressing sutures are placed on the fascia
- The surplus vaginal skin is excised and the skin is closed
- The repair is traditionally performed under regional or general anaesthesia, but repair of a mild to moderate cystocele can also be performed under local anaesthesia, allowing early mobilisation.

**Paravaginal repair**

- Abdominal approach to correct anterior defect
- The retropubic space is opened through a Pfannenstiel incision and the bladder is swept medially, exposing the pelvic sidewall
- The lateral sulcus of the vagina is elevated and re-attached to the pelvic sidewall using interrupted sutures
- A cure rate of >95% has been reported (may also be done laparoscopically).

**Posterior compartment defect:**

**Posterior colpoperineorrhaphy (posterior repair)**

- Appropriate for correction of a rectocele and deficient perineum
- It involves repair of a rectovaginal fascial defect and removal of excess vaginal skin. Care must be taken when removing the redundant vaginal skin, as vaginal narrowing can result in dyspareunia.
Perinoplasty
- Is performed by placing deeper sutures into the perineal muscles, building up the perineal body to provide additional support.

Enterocele repair
- Similar to that of posterior colporrhaphy.
- The vaginal epithelium is dissected from the enterocele sac, which is closed with a purse-string suture.

A Prolapse: surgical management; uterovaginal and vault

Uterovaginal (apical) prolapse

Vaginal Hysterectomy
- May be combined with other procedures in cases where there is significant uterine descent or menstrual problems
- Manchester repair (or Fothergill repair)
- Now rarely performed
- Cervical amputation is followed by approximation and shortening of the cardinal ligaments anterior to the cervical stump
- This is combined with an anterior and posterior colporrhaphy.

Sacrouterinepexy
- Can be done if the patient wishes to preserve the uterus
- The uterus and cervix are attached to the sacrum using a bifurcated non-absorbable mesh.

Vaginal vault prolapse

Sacropinous ligament fixation
- Involves suturing the vaginal vault to the sacrospinous ligaments, using a vaginal approach.
- Has a low immediate postoperative morbidity and success rate of 70-85%.

Sacrocolpopexy
- The vault is attached to the sacrum using a non-absorbable mesh, can be performed either as an open procedure or laparoscopically.
- It has a higher success rate, of around 90%, and a better anatomical result than sacrospinous fixation.

Colpocleisis
- The vaginal is either partially or completely closed
- Indicated in woman who are not sexually active with complete procidentia / failed previous pelvic floor surgery.
**Activity:** Choose a type of Repair Operation; arrange to attend Theatre to observe this surgery. Reflect on your experience below:
Prolapse: Conservative Management

**Prevention of pelvic organ prolapse:**
- Reduction of prolonged labour.
- Reduction of trauma caused by instrumental delivery.
- Encourage persistence with postnatal pelvic floor exercises
- Weight reduction
- Treatment of chronic constipation
- Treatment of chronic cough (including smoking cessation)

**Physiotherapy**
Physiotherapy has a role to play in the management of prolapse in younger women, who find intravaginal devices unacceptable and are not yet willing to consider definitive surgical treatment.

- **Pelvic Floor Exercises:**
  Are most effective when taught under the direct supervision of a physiotherapist, these will improve the tone in young parous women but are unlikely to benefit older women with significant uterovaginal prolapse.
- Biofeedback and vaginal cones.

**Intravaginal devices (pessaries)**
Vaginal pessaries offer a further conservative line of therapy for women who decline surgery, who are unfit for surgery, or for whom surgery is contraindicated.

- The Ring Pessary is most commonly used and is available in a number of different sizes, the ring is placed between the posterior aspect of the symphysis pubis and posterior fornix of the vagina.
- The Popy Shelf and Gelhorn pessaries can be used when a correctly sized ring pessary will not sit in the vagina and / or where the perineum is deficient (it may be difficult to insert and remove, so its use is becoming less common).
- Cube and Donut pessaries are, very rarely used for significant prolapse, when others are not retained.
- Milex Shaatz Pessary is used for a mild prolapse complicated by a mild cystocele.

**Factors influencing management of prolapse:**
- Severity of symptoms
- Extensions of signs
- Age, parity and wish for further pregnancies
- Patient’s sexual activity
- Presence of aggravating features such as smoking and obesity
- Urinary symptoms
- Other gynaecological problems such as menorrhagia.
Types of Pessaries

The Ring Pessary

- Used for management of a 1\textsuperscript{st} – 2\textsuperscript{nd} degree prolapse.
- Can be used if sexually active.

Gellhorn Pessary

- Second line management when Ring Pessary not successful.
- Used for management of 3\textsuperscript{rd} – 4\textsuperscript{th} degree prolapse.

Donut Pessary

- Second line management when Ring / Gellhorn / Shelf Pessary not successful.
- Used for management of 3\textsuperscript{rd} – 4\textsuperscript{th} degree prolapse.

Cube Pessary

- Used for management of 1\textsuperscript{st} to 4\textsuperscript{th} degree prolapse.
- Patient able to self manage pessary.
- Can be used if sexually active.
Poppy / Shelf Pessary

- Used as $2^{nd}$ / $3^{rd}$ line management when the Ring / Gellhorn Pessary not successful.
- Used for management of $3^{rd}$ – $4^{th}$ degree prolapse.
- Consider Poppy Pessary if erosion with Shelf Pessary.

Milex Shaatz Pessary

- Used for management of a $1^{st}$ – $2^{nd}$ degree prolapse.
- Can be used if sexually active.
**Activity:** Decision making regarding the type of pessary to utilise, for a patient who a pessary, other than a ring is used, eg Cube or Gelhorn. Consider what factors were important in the decision making and describe additional advice Patient will require. Consider risks associates with specific types of pessaries.
2:4 Potential problems relating to vaginal pessaries

**Activity:** Familiarise yourself with the Algorithms (Appendices 2 and 3) and the Protocol governing the management of Patients at the Gynaecology Nurse Led Vaginal Pessary Clinic.
2:5 The Nurses Role and Responsibility In vaginal Pessary Management

When developing new skills, it is not the activity that is the issue, but the context in which it is undertaken that is important. Integral to this is accountability, which encompasses responsibility, autonomy and authority. The exercise of accountability requires the practitioner to seek to achieve and maintain high standards of care. Each registered nurse, midwife or health visitor must justify any action or decision not to act (NMC 2018).


2:6 Infection Control Aspects of Vaginal Pessary Management.

“Standard Infection Control Precautions:
• must be used by all healthcare workers to prevent the spread of microorganisms that may cause infection
• must be used in all care settings
• are used to protect you, the patient you are caring for and others i.e. Health Care Workers, carers, friends, visitors, relatives and patients.
• are used at all times in the care setting whether an infection is known to be present or not.”

The 9 Elements of Standard Infection Control Precautions:
1. Hand Hygiene
2. Personal Protective Equipment
3. Prevention of occupational exposure
5. Cleanliness of care equipment
6. Cleanliness of the environment
7. Safe handling of linen
8. Safe disposal of waste
9. Patient Placement

**Activity:** Discuss the 9 elements of Standard Control of Infection Precautions in relation to the management of a vaginal pessary Patient.
Management of Patient with a Vaginal Pessary
Contents

Section 3

3:1 Theoretical Assessment

3:2 Supervised Practice and Assessment

3:3 Guidelines for assessor

3:4 Assessment of Skills Acquisition
3:1 Theoretical Assessment

Vaginal Pessary Management

This is a self-assessment of core knowledge skills in management of the Patient with a vaginal pessary.

You should complete this section before undertaking supervised practice.

The answers are not provided. You are encouraged to return to the text or references / bibliography for the answers.

List the different types of vaginal prolapse?

What are the indications for the use of a Ring Pessary?

What are the indications for the use of a Popy Shelf Pessary?

What are the indications for the use of a Cube Pessary?

What are the indications for the use of a Milex Shaatz Pessary?

What are the indications for the use of a Gelhorn Pessary?
What are the indications for the use of a Donut Pessary?

Describe the process of removing and replacing a Ring Pessary.

Describe the process of removing and replacing a Popy Shelf Pessary.

Describe the process of removing and replacing a Cube Pessary.

Describe the process of removing and replacing a Milex Shaatz Pessary.

Describe the process of removing and replacing a Gelhorn Pessary.

Describe the process of removing and replacing a Donut Pessary.
Can you list the 9 elements of the Standard Control of Infection Precautions?
1. 
2. 
3. 
4. 
5. 
6. 
7. 
8. 
9.

Consider Patients in whom a Ring Pessary is not suitable for, and describe the alternative options along with the indications.
Scenarios:

Mrs Brown attends for her 6 month change of Donut Pessary, she complains of an odorous discharge. How would you proceed?

Ms White had a Gelhorn Pessary fitted a fortnight ago, it has fallen out. What arrangement would you make for this lady?

Mrs Black attends for her 6 month change of Ring Pessary, she has had some vaginal spotting for a few weeks. On speculum examination an ulcerated area is noted how would you proceed?

Mrs Green attends for her 6 month change of Popy Shelf Pessary, she states she has had some vaginal bleeding off and on over the last month. Speculum examination reveals no cause for this bleeding, how would you proceed?

Miss Grey calls the helpline to say she is unable to remove her Cube Pessary, which has been in-situ for 2 weeks. Miss Grey she has no symptoms of note, but would like to be sexually active, what would you advise?
List the different types of vaginal prolapse?

What are the indications for the use of a Ring Pessary?

What are the indications for the use of a Popy Shelf Pessary?

What are the indications for the use of a Cube Pessary?

What are the indications for the use of a Milex Shaatz Pessary?

What are the indications for the use of a Gelhorn Pessary?

What are the indications for the use of a Donut Pessary?

What are the contraindications for the use of a Shelf Pessary?
3:2 Supervised Practice and Assessment

Following completion of the theoretical component, a **minimum of 10** Patients for management plans of Ring Pessaries and **minimum of 3** management plans for each pessary inclusive of Popy Shelf, Cube, Melix Shaatz, Gelhorn and Donut Pessaries (Appendices 1) should be completed under the supervision of an Assessor within your own clinical area and using the assessment criteria within this pack.

**Who can be an Assessor?**
Assessors must meet the following criteria:
- An assessor is a practitioner who has been identified as suitable by the Clinical Director for Gynaecology and / or UroGynaecologist and Senior Nurse for Gynaecology Services.

**Guidelines for Assessors:**
The Nurse should undertake a **minimum of 10** patients for management plans of Ring Pessaries and **minimum of 3** management plans for each of Popy Shelf, Cube, Melix Shaatz, Gelhorn and Donut Pessaries inclusive of:
- Consultation pre procedure
- Removal of Pessary
- Speculum examination and assessment of vaginal tissue
- Vaginal swab taking
- Insertion of Vaginal Pessary
- Comprehension of local guidelines for the management of Patients with a Vaginal Pessary
- Patient Education
- Documentation

The Guidelines supporting the Nurse Led Pessary Clinic should be used throughout the Patient management plans.

**All practitioners should ensure they have the necessary knowledge and skills required to manage the care of a patients with vaginal pessaries.**

The “completion of programme” record should be signed by the Assessor, one copy to be kept in the Nurse’s portfolio within the Clinical area, one copy to Senior Nurse for Gynaecology Services (for information) and one kept in the Nurses own Clinical Professional Development file.

Senior Charge Nurses should keep a record of all staff who have successfully completed this Programme.
### 3.3 Guidelines for Assessors

The following grid contains criteria for assessment. It should be used both by the Learner, in identifying how the learning undertaken within this programme should be applied in practice, and also by the Assessor, in determining the competency of the Learner.

Standard Statement: e.g. **The practitioner is competent in the management of the Patient with a Vaginal Pessary.**

During supervised practice the Assessor must ascertain that the individual demonstrated appropriate knowledge and / or skills in relation to all of the following:

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Signature of assessor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates understanding of the management of the patient with a Vaginal Pessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates safe and effective practice in relation to the management of the patient with a Vaginal Pessary.</td>
<td></td>
</tr>
<tr>
<td>Applies knowledge of correct procedure in relation to the management of the patient with a Vaginal Pessary.</td>
<td></td>
</tr>
<tr>
<td>Satisfactorily performs and gives rationale for best practice in relation to Pessary Management.</td>
<td></td>
</tr>
<tr>
<td>Utilises knowledge of potential complications, risks and hazards associated with the management of the patient with a Vaginal Pessary and effectively monitors the patient prior to, during and after the procedure.</td>
<td></td>
</tr>
</tbody>
</table>
3.4 Assessment of Skill Acquisition

Assessor: 
Job Title: 

Practitioner: 
Job Title: 

Clinical Skill: MANAGEMENT OF PATIENT WITH A VAGINAL PESSION

For competence in Ring Pessary management:
Practitioners should be assessed until competence is achieved in all domains or if competence is achieved on first attempt, they must undergo a minimum of 6 observations of Ring Pessary management. Competence is achievement when all criteria are met in all domains. Assessors should indicate if competence has been achieved in each domain by circling ‘YES’ or ‘No.’ Feedback should be entered in each remarks box, identifying criteria to be achieved or demonstrated.

For additional competences in Cube, Popy Shelf, Milex Shaatz, Doughnut and Gelhorn Pessary management, the practitioner will undergo a minimum of 3 supervised pessary changes for each device.

<table>
<thead>
<tr>
<th>Assessment Criteria for a Ring Pessary</th>
<th>Signature &amp; Date of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates understanding of the management of the patient with a Ring Pessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates safe and effective practice in relation to the management of the patient with a Ring Pessary.</td>
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<td>Satisfactorily performs and gives rationale for best practice in relation to Ring Pessary Management.</td>
<td></td>
</tr>
<tr>
<td>Utilises knowledge of potential complications, risks and hazards associated with the management of the patient with a Ring Pessary and effectively monitors the patient prior to, during and after the procedure.</td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Supervised Evaluations for Ring Pessary: . . . . . . . .
### Assessment Criteria for a Popy Shelf Pessary

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Signature &amp; Date of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates understanding of the management of the patient with a Popy Shelf Pessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates safe and effective practice in relation to the management of the patient with a Popy Shelf Pessary.</td>
<td></td>
</tr>
<tr>
<td>Applies knowledge of correct procedure in relation to the management of the patient with a Popy Shelf Pessary.</td>
<td></td>
</tr>
<tr>
<td>Satisfactorily performs and gives rationale for best practice in relation to Popy Shelf Pessary Management.</td>
<td></td>
</tr>
<tr>
<td>Utilises knowledge of potential complications, risks and hazards associated with the management of the patient with a Popy Shelf Pessary and effectively monitors the patient prior to, during and after the procedure.</td>
<td></td>
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</tbody>
</table>

**Total Number of Supervised Evaluations for Popy Shelf Pessary:**  

### Assessment Criteria for a Cube Pessary

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Signature &amp; Date of assessment</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates understanding of the management of the patient with a Cube Pessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates safe and effective practice in relation to the management of the patient with a Cube Pessary.</td>
<td></td>
</tr>
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<td>Satisfactorily performs and gives rationale for best practice in relation to Cube Pessary Management.</td>
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<td></td>
</tr>
</tbody>
</table>

**Total Number of Supervised Evaluations for a Cube Pessary:**  

### Assessment Criteria for a Milex Shaatz Pessary

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Signature &amp; Date of assessment</th>
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<tbody>
<tr>
<td>Demonstrates understanding of the management of the patient with a Milex Shaatz Pessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates safe and effective practice in relation to the management of the patient with a Milex Shaatz Pessary.</td>
<td></td>
</tr>
<tr>
<td>Applies knowledge of correct procedure in relation to the management of the patient with a Milex Shaatz Pessary.</td>
<td></td>
</tr>
<tr>
<td>Satisfactorily performs and gives rationale for best practice in relation to Milex Shaatz Pessary Management.</td>
<td></td>
</tr>
<tr>
<td>Utilises knowledge of potential complications, risks and hazards associated with the management of the patient with a Milex Shaatz Pessary and effectively monitors the patient prior to, during and after the procedure.</td>
<td></td>
</tr>
</tbody>
</table>

**Total Number of Supervised Evaluations for a Milex Shaatz Pessary:**  

### Assessment Criteria for a Gelhorn Pessary

<table>
<thead>
<tr>
<th>Description</th>
<th>Signature &amp; Date of assessment</th>
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</thead>
<tbody>
<tr>
<td>Demonstrates understanding of the management of the patient with a Gelhorn Pessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates safe and effective practice in relation to the management of the patient with a Gelhorn Pessary.</td>
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</tr>
<tr>
<td>Applies knowledge of correct procedure in relation to the management of the patient with a Gelhorn Pessary.</td>
<td></td>
</tr>
<tr>
<td>Satisfactorily performs and gives rationale for best practice in relation to Gelhorn Pessary Management.</td>
<td></td>
</tr>
<tr>
<td>Utilises knowledge of potential complications, risks and hazards associated with the management of the patient with a Gelhorn Pessary and effectively monitors the patient prior to, during and after the procedure.</td>
<td></td>
</tr>
</tbody>
</table>

**Total Number of Supervised Evaluations for a Gelhorn Pessary:** ............

### Assessment Criteria for a Donut Pessary

<table>
<thead>
<tr>
<th>Description</th>
<th>Signature &amp; Date of assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates understanding of the management of the patient with a Doughnut Pessary.</td>
<td></td>
</tr>
<tr>
<td>Demonstrates safe and effective practice in relation to the management of the patient with a Doughnut Pessary.</td>
<td></td>
</tr>
<tr>
<td>Applies knowledge of correct procedure in relation to the management of the patient with a Doughnut Pessary.</td>
<td></td>
</tr>
<tr>
<td>Satisfactorily performs and gives rationale for best practice in relation to Doughnut Pessary Management.</td>
<td></td>
</tr>
<tr>
<td>Utilises knowledge of potential complications, risks and hazards associated with the management of the patient with a Doughnut Pessary and effectively monitors the patient prior to, during and after the procedure.</td>
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</tbody>
</table>

**Total Number of Supervised Evaluations for a Donut Pessary:** ............

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DRAFT
1. **Professionalism Criteria**  
- applies ethical principles to inform decision making  
- involves patient in decision making process  
- practices in accordance with professional code  
- demonstrates autonomy and initiative  
- maintains accurate record keeping

2. **Patient Assessment Criteria**  
- assesses patient suitability for the procedure  
- selects equipment (providing rationale for choice)  
- discusses the potential psychological impact with the patient  
- critically analyses potential risks

3. **Knowledge and Application Criteria**  
- demonstrates knowledge of relevant Anatomy & Physiology  
- provides appropriate patient information  
- discusses indication and contraindications with patient  
- seeks information from appropriate sources when necessary

4. **Communication Criteria**  
- skill explained to patient / carers to obtain informed consent  
- practitioner demonstrates accurate and legible documentation of skill

5. **Organisational Criteria**  
- correct equipment is prepared and checked  
- skill is carried out in a timely, logical sequence  
- responds appropriately to any complications

6. **Technical Ability Criteria**  
- skill is performed accurately and efficiently  
- recognises limitations of technical ability and seeks assistance as required  
- takes appropriate action to reduce risk of complications i.e. aseptic technique as required
7. Overall Competence Criteria
- achievement of all of the above qualities
- practitioners’ ability to practice skill in accordance with standardised procedure
- demonstrates aptitude to reflect on learning and identifies areas for further learning.

Assessors Feedback:
(Indicate areas for improvement as necessary)

Agreed Action Plan (Between Assessor and Practitioner)

- The learner agrees to undertake 10 patient management plans relating to Ring Pessaries and 3 patient management plans relating to each of the following pessaries, Popy Shelf / Cube / Milex Shaatz / Gelhorn / Donut.

Time to achieve action plan:
1 week 2 weeks other, please specify . . . . . . . . . . . . . .

Practitioner Signature . . . . . . . . . . . . . . . . . . . . . . . . Date . . . . . . . . . . . . .
Assessor Signature . . . . . . . . . . . . . . . . . . . . . . . . . Date . . . . . . . . . . . . .
Management of Patient with a Vaginal Pessary

Contents

Section 4

4:1 Record of completion of programme

4:2 Literature Review

4:3 Vaginal Pessary Management Package Evaluation Form

4:4 Appendices:

1. Clinical Consultation Observed Management Plan

2. Guidelines for Vaginal Speculum Examination and Swab Taking

3. Algorithm 1: Management of Patient with Vaginal Pessary at the Nurse Led Clinic

4. Algorithm 2: Management of Patient with a Vaginal Pessary and PV Bleeding

5. Emergency Assessment Sheet for Patient with Vaginal Pessary Device

6. Flow Chart Facilitating Pessary Telephone Calls to Gynaecology Assessment Unit (GAU), Ninewells Hospital

7. Flow Chart Facilitating Pessary Telephone Calls to Area 3, Ninewells Hospital and Women’s Unit, PRI

8. Protocol for use of Vaginal Oestrogen in Patients with a Vaginal Pessary

9. Vaginal Pessary Advice, Patient Information Leaflet
**NHS Tayside University Hospitals**  
**Management of the patient with a Vaginal Pessary**  
**Section 4**  
**4:1 Record of Completion of Programme**

All staff must complete and return this slip to Senior Nurse for Gynaecology Services, NHS Tayside for information, a copy should be retained by the Senior Charge Nurse of your clinical area.

**Full Name:**  
**Profession:** Nursing  
**Job Title:**  
**Clinical Area:**  
**Hospital:**

<table>
<thead>
<tr>
<th>Completion</th>
<th>Signature (Practitioner)</th>
<th>Signature (Assessor)</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of self directed pack</td>
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</tr>
<tr>
<td>Completion of theoretical assessment/s</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completion of practical assessment/s</td>
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<tr>
<td>Competent to carry out the Management of the patient with a Vaginal Pessary</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
4:2 Literature Review

The General Medical Council (2013). Good Medical Practice handbook. GMC, London


Nursing & Midwifery Council (NMC 1995): The Scope of Professional Practice. NMC London.


46.


**Suggested reading**
Gynaecology Illustrated
Matthew M. Garry, A.D.T. Goven, C.H. Hodge, Robin Callander
Churchill Livingstone
Edinburgh & London 2011

Notes for the DRCOG
Peter Kaye
Second Edition
Churchill Livingstone 2001
The Uterus
Edited by T. Chard and J.G. Grudzinskas
Cambridge University Press 1994
Oxford Handbook of Obstetrics and Gynaecology.
Arulkumaran, S., Fowble, A., Symonds, I.M
# APPENDIX 1

**Clinical Consultation Observed Management Plan**

**Session Number:**

**Patient Code/ID:**

**Date:**

**Assessor:**

<table>
<thead>
<tr>
<th>Undertaken successfully: Yes/No/Not Applicable</th>
<th>Comments by Assessor</th>
</tr>
</thead>
<tbody>
<tr>
<td>History taking</td>
<td></td>
</tr>
<tr>
<td>Explanation of procedure</td>
<td></td>
</tr>
<tr>
<td>Physical preparation of patient</td>
<td></td>
</tr>
<tr>
<td>Type of pessary</td>
<td></td>
</tr>
<tr>
<td>Removal of pessary</td>
<td></td>
</tr>
<tr>
<td>Speculum examination and assessment of vaginal tissue</td>
<td></td>
</tr>
<tr>
<td>Insertion of pessary</td>
<td></td>
</tr>
<tr>
<td>Comprehension of local guidelines for the management of patient with vaginal pessary</td>
<td></td>
</tr>
<tr>
<td>Patient education</td>
<td></td>
</tr>
<tr>
<td>Documentation process</td>
<td></td>
</tr>
</tbody>
</table>

**Reflection on session by learner:**

**Signature of learner:**

**Date:**

**General comments on session by Assessor:**

**Signature of Assessor:**

**Date:**
APPENDIX 2

Vaginal examination Depending on the reason for the examination, digital vaginal examination if necessary may occur before or after a speculum examination.

- Part the labia and insert gloved and lubricated index and middle finger into the vagina. To assess the genital floor tone, ask the woman to ‘bear down’ and ‘squeeze’. Advise the woman that you will be applying light pressure to the posterior fourchette and this will help the muscles to relax.

- Speculum examination The Cusco bivalve speculum is most commonly used for routine examination and inspection of the cervix. There are other specula, including the Sims, which are useful for complex examinations, continence assessment and during surgical procedures. Follow the guidelines below to insert the speculum correctly. Ensure that the correct size and type of speculum is selected. Offer to demonstrate the speculum. Inform the woman about the sounds associated with the speculum use, if appropriate.

GENITAL EXAMINATION IN WOMEN

- Ensure the speculum is lubricated with water or water-based lubricant (be aware that lubricant can obscure cervical cytology tests and swab results, so may not be used in some examinations) and warmed, if required.

- Ensure that the blades of the Cusco speculum are closed for insertion. Introduce, or instruct the woman to introduce, the speculum. The speculum should be inserted into the vagina in a slightly downward motion. If the labia are flaccid, gently opening them with your other hand limits any dragging or pulling. The insertion should be a slow and seamless procedure. Ensure that the speculum points down towards the posterior of the woman and insert into the vagina until flush with the perineum. Ensure no pubic hair is caught, and that there is no pressure on delicate structures such as the urethral meatus and ditoris. In the case of prolapsed vaginal walls, sheath the speculum with a condom or a non-latex glove finger with the end cut off, or use a wider or long-bladed speculum. Check the woman’s comfort – either with eye contact, verbally or using a chaperone.

- Open the speculum and look at the cervix (it is not necessary to fully open the speculum). To do this you may need to ask the woman to cough or change position. Fix or hold the Cusco speculum into the correct position. Note the colour, size, position, appearance, secretions and texture of the cervix. Note any polyps or contact bleeding, presence/absence of threads if intrauterine device is in situ. In a woman who has never had a pregnancy, the cervical os will be small and round, otherwise it will often look like a horizontal line and can be irregular. Note any nabothian cysts or follicles, which are a normal finding and have the appearance of small yellow nodules. Note that the cervix is usually midline, extending 2cm into the vagina. More than 3cm could indicate vaginal prolapse.

- Note that in pregnancy the cervix will look different and may have a bluish/purple tint, and normal vaginal discharge may also appear heavier. Note that the cervix and os also change position and appearance at different stages of the menstrual cycle and pre- and post-menopause. If collecting samples for sexual health screening or cytology, collect them according to local protocol using the pathology swabs in current use. It is important to remember that the cervical smear should be the first specimen collected regardless of any others to be collected.

- Remove the speculum carefully ensuring that you have not trapped the vaginal walls or cervix in the speculum as it closes. Remove with the speculum slightly open. Examine the vagina as the speculum is removed assessing the vaginal walls for infection, cysts or foreign bodies. Rugae are a normal finding in younger women. In older women you will need to be aware that the vaginal walls are thinner and drier and be careful not to cause damage with the speculum.

RCN: Genital Examination in Women (2016).
**Appendix 3**

**Algorithm 1: Management of Patient with Pessary at Nurse Led Clinic**

1. Obtain Patient History
2. Inform patient of procedure and obtain consent
3. Afford patient privacy to undress and position herself on the examination couch (assist if required).
4. Remove pessary, assess the type and size of speculum that you require

**Vulval / Perineal & Speculum Examination**

- **Any other concerns, e.g., cervical abnormality**
  - Medical Review
- **Vaginal Bleeding**
  - Refer Algorithm 2: Ring Pessary Patient with Vaginal Bleeding
- **No Abnormality Detected. (Routine Cervical Smear if appropriate)**
- **Offensive Vaginal Discharge / Erosion / Ulceration / Granulation**
  - Remove Pessary
  - Refer to Vaginal Oestrogen protocol
  - 3 Review at Nurse Led Clinic in 4-6 weeks

5. Ensure patient is comfortable after procedure

**Discharge not changed:**
- High Vaginal Swab
- GOPD Consultant Review 6 weeks

**Record Details in notes and generate appropriate letter/s.**

**Arrange follow up, or as requested by medical staff, issue with appropriate patient information leaflet**

Management of Patient with Pessary and PV Bleeding

For patients reporting episodes of vaginal bleeding an in-depth history of the bleeding is required inclusive of:
- Number of episodes
- how often they have occurred
- how heavy episode are etc

Algorithm 1: Algorithm for Patient with a Pessary and PV Bleeding

1. PV Bleeding
   - Remove Pessary
2. Vaginal / Perineal / Speculum Examination
3. Cervix Normal
   - Potential local cause of bleeding e.g. ulceration, excoriation
   - Leave Pessary out.
   - Refer to Protocol for use of Vaginal Oestrogens in women with vaginal pessary.
   - Review nurse clinic 4-6 weeks.
4. No Abnormalities Detected
   - Leave Pessary out.
   - Refer as per woman with PMB. I.e Option 1:
     - Issue with PMB clinic appointment.
   - OR Option 2:
     - Nurse organises an URGENT ultrasound scan and GOPD review.
   - Scan Request Form: PMB ET & Ovaries
   - END
5. Woman is not menopausal and has uterus
   - Arrange medical review.
   - END
6. Post menopausal woman with uterus
   - At 4 - 6 week Follow Up appointment
   - Bleeding not settled
     - Speculum Examination
   - No Abnormalities Detected
     - Arrange medical review
     - END
   - Abnormality noted
     - Arrange medical review
     - END
7. Woman is not menopausal and has uterus
   - Medical Review END
8. Potential local cause of bleeding e.g. ulceration, excoriation
   - Leave Pessary out.
   - Refer to Protocol for use of Vaginal Oestrogens in women with vaginal pessary.
   - Review nurse clinic 4-6 weeks.
9. Bleeding settled
   - Speculum Examination
   - No Abnormalities Detected
     - Replace with new prescribed Pessary
     - END
   - Abnormality noted
     - Arrange medical review
     - END
10. At 4 - 6 week Follow Up appointment
    - Bleeding not settled
      - Speculum Examination
      - No Abnormalities Detected
      - Replace with new prescribed Pessary
      - END
11. No Abnormalities Detected
    - Replace with new prescribed Pessary
    - END
12. NB: In the event of further episodes of PV bleeding (despite possible local cause) discuss case with medical staff.
13. 6 month follow up at nurse clinic.
    - Advised to contact clinic staff at the first sign of further bleeding.
    - END

# APPENDIX 5

**DRAFT** Emergency Gynaecology Assessment Sheet for Patient with Vaginal Pessay Device

**ALL PESSARY CALLS MUST BE TRIAGED USING LOCAL ALGORITHM GUIDANCE**

Pale Pink section completed by individual taking telephone call. Darker Pink completed by individual triaging call.

<table>
<thead>
<tr>
<th>Date:</th>
<th>Time of Call:</th>
<th>Referred by: Self: Other:</th>
<th>Call accepted by:</th>
<th>Call triaged by: (Time):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Surname</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Forename</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient CHI</td>
<td></td>
<td>Call Summary: Unable to Void Pain Bleeding Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Contact Number</td>
<td></td>
<td>Call Outcome: Triage Nurse to return call: Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cons Gynae:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>last clinical visit:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type and Size of Devise</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature:</td>
<td>Signature:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Initial Nurse Assessment by: Name: Signature: (Time: )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Surname</td>
<td></td>
</tr>
<tr>
<td>Patient Forename</td>
<td>Temperature:</td>
</tr>
<tr>
<td>Patient CHI</td>
<td></td>
</tr>
<tr>
<td>Addressograph Label</td>
<td>Blood Pressure: Sа О:</td>
</tr>
</tbody>
</table>

**AFFIX URINALYSIS PRINT OUT OR RECORD MANUALLY**

Admitting Consultant:
Assessed by (Doctors name and designation) Date Time Signature
Presenting History:

<table>
<thead>
<tr>
<th>Age:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Parity:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 6 Flow Chart Facilitating Pessary Telephone Calls to Gynaecology Assessment Unit (GAU), Ninewells Hospital

Complete details on Triage Sheet

- Pessary has fallen out
  - UNABLE TO PASS URINE, IN PAIN, SIGNIFICANT BLEEDING; CONSTITUTES EMERGENCY
    - INSTRUCT PATIENT TO ATTEND GAU ASAP IF CAN DO SO SAFELY OTHERWISE CONTACT GP
      - END
  - ASCERTAIN CONSULTANT WHO PATIENT IS UNDER
    - REDIRECT TELEPHONE CALL TO IDENTIFIED CONSULTANTS AND SECRETARY FOR MANAGEMENT PLAN TO BE AGREED WITH CONSULTANT
    - SECRETARY TO INFORM WAITING LIST OFFICE WHERE TO APPOINT PATIENT
      - END

- Slight bleeding, Incontinence, Constipation, Discomfort, Pessary Slipping, Patient Advice Enquiry
  - Non urgent reply
    - Designated Nurse will telephone back (no time given)

- Nurse telephones Patient confirms non urgent complication
  - Summarises telephone consultation and outcome on the triage form
      - END

- Nurse telephones Patient confirms non urgent complication
  - Summarises telephone consultation, ascertains medical advice required

- Patients details and call summary given to on call Registrar to decide on further management and liaise directly with patient
      - END

Developed By: SCN E Coupar & CN L Donald, May 2015
Reviewed By: D Brand, Senior Nurse Gynaecology Services, NHS Tayside, June 2019
Flow Chart Facilitating Pessary Telephone Calls to Area 3, Ninewells Hospital and Women’s Unit, PRI

- Pessary has fallen out.
- Pessary Patient who attends Consultant Clinic.
- UNABLE TO PASS URINE, IN PAIN, SIGNIFICANT BLEEDING.

Patient who usually attends Nurse Led Pessary Clinic.

- Slight bleeding, Incontinence, Constipation, Discomfort, Pessary Slipping.
- Non urgent reply.
  - Receptionist ascertains Consultant who Patient is under.
  - Receptionist redirects call to Consultant’s Secretary for management plan to be agreed with Consultant.
  - Secretary to inform Waiting List Office where to appoint Patient.
  - END

- Nurse telephones Patient, documents telephone consultation on continuation sheet, file this in notes (when they are available).
  - Dictate letter to appropriate individuals if required.
  - Nurse requests Reception staff to enter details onto electronic Patient record system.

Outcome depending on history:
- If follow up is required on Consultant’s Clinic (redirect call to Consultant’s Secretary for appointment date).
  - Secretary to inform Waiting List Office where to appoint Patient.
- If no immediate intervention is required, follow up as indicated at pre-arranged Clinic appointment.

END

Reviewed by: D Brand, Senior Nurse for Gynaecology Services, NHS Tayside - June 2015
**APPENDIX 8**

**Protocol for use of Vaginal Oestrogen in Patients with a Vaginal Pessary**

If vaginal oestrogen is required, please prescribe nightly dose for 2 weeks, then alternate nights for 2 weeks and then twice weekly for 4-6 months – Vagifem pessaries or Orthogynest cream.

**Asymptomatic Patients with normal vaginal mucosa**
(No PVB, healthy mucosa)

With the patient who has no bleeding and, on removal of the pessary, the vaginal walls are healthy, vaginal oestrogen is not required.

**Asymptomatic Patient’s with superficial ulceration of vaginal mucosa**
(No PVB, bleeding at removal)

With the Patient who has no bleeding since last pessary insertion BUT on removal of the pessary, the vaginal walls are superficially ulcerated, oestrogen may be required (see contraindications). Treatment as above.
In the presence of mild ulceration with minimal or no bleeding the pessary can be replaced. If ulceration is more extensive or contact bleeding has been precipitated by pessary removal then the pessary should not be replaced until review at 4 to 6 weeks.

**Symptomatic Patients**
(Patients with PVB while pessary in place) – see flow chart

A Patient who complains of bleeding whilst their pessary is in situ may require further investigation prior to treatment. All patients will need the pessary to be removed; the vaginal mucosa to be inspected for any suspicious appearance and the pessary left out for 4 to 6 weeks.

If the patient still has a uterus or cervix further investigation with transvaginal ultrasound is required. An endometrial thickness of >3mm will require an endometrial biopsy to identify any malignancies or hyperplasia. An endometrial thickness of \(<= 3mm\) does not require a biopsy and vaginal oestrogen may be started as above.

**Oestrogen therapy should not be commenced until results available.**

An ultrasound scan may be performed immediately in clinic if a suitably trained member of staff is available to do so. If no-one is available;

**Option 1.** A Patient should only be given an urgent PMB slot if the vaginal walls do not look ulcerated or blood is seen coming through the cervical os.

**Option 2.** If local causes seen eg atrophy or erosion, then the next available slot (within 2 weeks) should be booked in the Gynaecology Ultrasound Department.

If the Patient has had a total hysterectomy (no uterus or cervix) and the vaginal vault is eroded / ulcerated but not suspicious, then vaginal oestrogen can be commenced immediately as above and the pessary left out for 4 to 6 weeks.
Any suspicious appearances on examination, or abnormal findings on scan, should be seen by the Registrar or Consultant responsible for that patient.

**Type of oestrogen**

The oestrogen used will depend upon the preference of the Patient and the frequency of use. Vagifem is licensed for long term use as required so should be used as first line for Patients with a pessary as it is likely that they will require vaginal oestrogen from time to time for the long term. Orthogynest cream may be used as an alternative but if use is frequent then Vagifem should again be discussed with the Patient. In studies Vagifem did not lead to endometrial thickening over 2 years of continuous use. The equivalent data for Orthogynest is not available.

**Contraindications to oestrogen use**

- Current or history of oestrogen dependent tumour
- Undiagnosed vaginal bleeding
- Thrombo-embolism
- Arterial disease
- Abnormal LFTs
APPENDIX 9

Vaginal Pessary Advice

Patient Information

The aim of this leaflet is to help you understand more about your prolapse and how using a vaginal pessary may help.

What is a Prolapse?
A prolapse is when the uterus or vagina comes down from its normal position in the pelvic cavity into the vaginal canal. It is caused by relaxation of the supporting structures of the pelvic floor. There are several different types of prolapse and symptoms depend on the type of problem. The usual symptoms include a feeling of 'something coming down', recurrent urinary tract infections, trouble emptying your bladder or bowels, discomfort with sexual intercourse and chaffing.

What can I do to improve the symptoms?
The symptoms of prolapse can be improved by reducing the pressure on the pelvic floor or strengthening the pelvic floor muscles.

This may be achieved by:
- Lose weight if overweight
- Stop smoking
- Avoiding constipation by increasing your fibre and fluid intake
- Regular pelvic floor exercises
- Avoid heavy lifting

What is a vaginal pessary?
Your doctor has recommended treatment with a vaginal pessary. This is a small device which is inserted into the vagina to hold the prolapse in place. Pessaries are made of silicone or acrylic and come in many different shapes and sizes. Ring pessaries are the most common, but may not be right for every woman. Your doctor will discuss with you which pessary is the most suitable treatment.
Benefits of a vaginal pessary include:
- Relief of pressure symptoms
- Make it easier to empty the bladder
- Relief of problems emptying the bowels
- Control of the deterioration of your prolapse

A complication of a vaginal pessary is ulceration of the vaginal wall. This causes discomfort and a blood stained discharge. The pessary will be removed for 2 – 4 weeks to allow the vagina to heal.

What happens next?
The doctor will examine you internally through your vagina to decide on the type and estimate the size of the pessary. It can sometimes take a few times to get the correct fit. After fitting your pessary, you will be asked to walk around, sit, squat, cough and strain to test if it is comfortable and remains in place. Please tell the doctor if it doesn’t feel right, even if it is the second, third or fourth pessary you have tried. Some pessaries are designed to be removed by the woman. You may be given advice on how to remove and insert your pessary.

If the vaginal pessary falls out or causes you any problems do not worry, just call the helpline number and we will arrange a return appointment for you.

Helpline Number:
You will find the contact details for the clinic you attended on the back of this leaflet, call this number in the first instance.

What happens after I have a pessary fitted?
Once you have found the best fit, you will be given a return appointment to be seen at the nurse clinic. This is to check the pessary is suiting you. The nurse will examine you vaginally and the pessary may be removed and cleaned. Further follow up appointments will be arranged usually at 6 month intervals. An early appointment may be arranged if there are any problems.

Commonly asked questions

I have a discharge is this normal?
Vaginal discharge is often increased by the presence of a pessary, but it should not smell offensive or be blood stained. If you experience either of these symptoms then phone the helpline for advice.

I have bleeding and I am worried. Is this normal?
This may or may not be due to the pessary. This should always be investigated by phoning the helpline for advice. You may either be advised to see your GP first or we will arrange to see you at the clinic.
What if I have any discomfort?
Once the pessary is fitted correctly you should be unaware it is there. However it can move if you strain to move your bowels or with heavy lifting. If this occurs you can try inserting a finger into the vagina and see if you can move the pessary into place or you can phone the helpline for advice. If you are in severe pain, you should phone the helpline.

What if I am in pain?
It is not normal to have pain with a vaginal pessary. Initially you may have slight discomfort after insertion. If you are in severe pain you must seek prompt assistance, either by phoning the helpline, your GP or NHS 24 for advice.

Can I have sexual intercourse whilst using a vaginal pessary?
Some pessaries may interfere with sexual intercourse. A ring pessary may be left in place during sex but other pessaries may literally get in the way. Some pessaries can be removed before sexual intercourse, such as a cube pessary. Your doctor will discuss this with you, but if you are unsure, please ask.

What if I have urinary problems?
Often a vaginal pessary will improve urinary symptoms. Rarely, you may find the pessary causes difficulty in urinating or urinary incontinence. If you experience either of these symptoms, phone the helpline for advice.

What happens if the vaginal pessary does not work?
Vaginal pessaries do not work for all women. You may decide that the symptoms are mild and that no other treatment is needed. Your doctor may discuss the option of a prolapse operation.

Should you have any problems with your pessary between now and your next appointment, please do not hesitate to contact us on the helpline.

Useful information
Please find below three links to other patient information sheets that you may find useful.

http://bsug.org.uk/patient-information.php


http://www.iuga.org/?page=patientinfo

Contact numbers:

Ninewells Hospital
Gynaecology Outpatient Department
Telephone: 01382 633864
Perth Royal Infirmary
Gynaecology Ward
Telephone: 01738 473426

Arbroath Infirmary
Nurse Office Outpatient Department
Telephone: 012410822547

Whitehills Health and Community Care Centre, Forfar
Appointments Secretary Arbroath
Telephone: 01241 822528

Links Health Centre, Montrose
Outpatient Reception
Telephone: 01674 817192