

14 Urogynae prolapse

Dear [Dr ____],

Advice and guidance response pertaining to [Patient name].

(use as required)

Asymptomatic prolapse

If a prolapse has been noticed incidentally, advise to consider pelvic floor exercises to prevent worsening of the prolapse. General advice to avoid constipation, minimise heavy lifting and reduce weight (ideally to BMI <30) is also helpful. [Manage constipation if present](#).

Symptomatic prolapse: surgery not desired/appropriate

First line of care is lifestyle modification and [pelvic floor exercises](#). Lifestyle modification includes weight reduction (ideally to BMI <30, minimising heavy lifting and avoiding/treating constipation.

Pessaries are a popular and successful treatment for most women. Surgery could be considered later if the woman cannot manage the prolapse symptoms with conservative treatment options.

For post-menopausal women, vaginal oestrogens can be helpful and can be used with a pessary in-situ e.g. Vagifem 10mcg, weekly. Please check for contraindications before prescribing.

Getting the right size of pessary takes an average of 3 attempts. The pessary should be the largest size that is comfortable and not felt. A finger should be able to be swept between the pessary and the wall of the vagina. It is possible to continue to have sexual intercourse with a ring pessary in situ. Many models such as silicone ring pessaries can be managed by the patient, if confident.

Women should be advised that they may experience increased discharge but should always seek advice with bleeding.

Discomfort, spontaneous expulsion or difficulties urination or defaecation may suggest a different size is needed. Most pessaries are changed at least every 6 months.

Types of pessaries

Ring pessaries can be used as first line for any type of prolapse. They can be made of PVC or silicone. Silicone pessaries can be self-managed if the woman is confident and able to do so. There are also different designs including ring with knob for bladder support in women who also have stress incontinence symptoms, and ring with support for use in vault prolapse or uterovaginal descent.

If a ring pessary is not sufficient to support the prolapse, Gelhorn or Shelf pessaries can be tried. These are not appropriate for women who still wish to be sexually active.

Discharge with a pessary

Vaginal discharge can be normal. A swab can be taken for fungal infection and treated appropriately. Consider local oestrogen treatment. The pessary may need more frequent replacement.

Constipation with a pessary

If constipation occurs after a recent fitting with a first or larger pessary then this may be because the pessary is too large. Otherwise the constipation should be treated as usual in the first instance with laxatives and increasing fibre and fluid intake.

Unable to remove pessary

A “stuck” pessary most commonly occurs if a pessary has been left too long in situ or if it was too large. The pessary may cause adhesions, erosions, infection and chronic discharge. There is a risk of fistula formation but this is low. If unable to remove the pessary, the patient requires referral.

Vaginal vault prolapse after hysterectomy

If it is minor (grade 1-2) i.e. above the hymen and not immediately visible at the entrance to vagina, then this can be managed with pelvic physio +/- fitting of a ring pessary. Ring pessaries are also an acceptable option for vault prolapse of all grades. Women should be referred for surgery to a urogynaecologist if they wish to pursue this option.

Urgent referral:

If a patient has a pelvic mass which may cause symptoms mimicking prolapse or if there is abnormal bleeding

Suspicious bleeding, ulcerated or non-healing areas in vagina/vulva noted at pessary change

Routine referral:

If a new patient presents with symptoms and there is no one in primary care able to offer pelvic physiotherapy and/or provide pessary fitting

To pessary/urogynaecology service if there are problems with an existing pessary including discomfort, difficulty retaining a pessary or abnormal discharge

If prolapse symptoms persist despite conservative treatment and patients are willing to consider surgery

Relevant guidance:

[Recommendations | Urinary incontinence and pelvic organ prolapse in women: management | Guidance | NICE](#)

[Urinary incontinence and pelvic organ prolapse in women | Treatment summaries | BNF | NICE](#)
[The British Society of Urogynaecology \(BSUG\)](#)

Patient resources:

[Pelvic organ prolapse | RCOG](#)

[Pelvic Organ Prolapse - A physiotherapy guide for women | POGP](#)

If referring back, please state that the referral has already been through Advice and Guidance and include previous correspondence so we don't duplicate advice.

With kind regards,

[Responding clinician name and role]