

Evaluation of vaginal pessary use by South African gynaecologists



Zeelha Abdool, MMed (O&G), FCOG (SA)
Department of Obstetrics and Gynaecology, University of Pretoria

Introduction. The use of vaginal pessaries for conservative management of pelvic organ prolapse (POP) is well established. However, there are limited data on current clinical practice among gynaecologists, and the aim of this survey was therefore to evaluate vaginal pessary use among South African gynaecologists.

Methods. An anonymous self-administered one-page questionnaire was designed by the author and given out to South African gynaecologists at a local obstetrics and gynaecology meeting in 2009.

Results. The response rate was 31.7% (133/420). Of the respondents, 23.6% (29/123) offered vaginal pessaries as first-line treatment for POP in their clinical practice. The ring pessary was the commonest pessary used for all compartmental defects. The two most favoured reasons for pessary use were surgical or anaesthetic risk (64.0%, 85/133) and patient declining surgery (49.6%, 66/133). Recurrent involuntary expulsion (51.9%, 69/133), discomfort (41.3%, 55/133) and opting for surgery (39.1%, 52/133) were the three top reasons for discontinuation of pessary use. Of the respondents 87.6% (92/105) indicated that they would review patients within 6 weeks after initial pessary insertion, and thereafter 45.8% (44/96) would review patients at 3 - 6-monthly intervals.

Conclusion. Compared with surveys elsewhere, fewer South African gynaecologists offer vaginal pessaries as first-line treatment to patients with symptomatic pelvic organ prolapse. Practice trends similar to those elsewhere included choice of pessary, follow-up interval and reasons for pessary discontinuation.

Currently there is a wide variation in surgical techniques performed for the treatment of pelvic organ prolapse (POP). In 2009 Maher *et al.* performed a Cochrane review on the many different surgical procedures for POP and concluded that there are insufficient data from randomised controlled trials to guide clinical practice optimally.¹ Numerous studies have shown that use of vaginal pessaries improves urinary, bowel, sexual and general quality of life symptoms associated with POP.²⁻⁶ However, in recent years their use to treat symptoms associated with pelvic organ prolapse and urinary incontinence has declined due to advances in gynaecological surgery. Currently it is widely accepted that the most common indications for vaginal pessaries as a treatment option for POP include co-morbid medical conditions, patients who still want to have children, to provide interim relief before surgery, and non-surgical treatment for those patients who prefer it.⁷ There are few data on the use of vaginal pessaries for POP in clinical practice. Recent studies have shown that pessaries are used by 98% of members of the American Urogynecologic Society (77% use them as first-line therapy for POP), 88% of Fellows of the American College of Obstetricians and

Gynaecologists^{8,9} and 86.7% of consultant obstetricians and gynaecologists in the UK.¹⁰ The aim of this study was to evaluate the use of pessaries by South African gynaecologists in their clinical practice.

Methods

Data were collected via an anonymous one-page self-administered questionnaire developed by the author. The survey was distributed to attendees at a local obstetrics and gynaecology meeting in 2009. The first part of the questionnaire addressed the demographics of the gynaecologists, while the second part enquired about the use of vaginal pessaries as first-line treatment for POP (yes/no), indications, choice of pessary with regard to the anterior, middle and posterior compartment (ring/donut/Gellhorn/cube/Gehrung/other), routine use of oestrogen cream (yes/no), patient follow-up (3-monthly, 3 - 6-monthly, more than 6-monthly), and the need for a formal training programme on vaginal pessary use. Data from the completed questionnaires were captured into a Microsoft Excel file and percentages were calculated. The study was registered with the National Health Research Ethics Council (No. 2713).

Results

One hundred and thirty-three attendees responded to the questionnaire, giving a response rate of 31.7%. Of the respondents, 69.1% (85/123) were members of the South African Society of Obstetrics and Gynaecology. The majority of the respondents were aged 36 - 55 years (61.1%, 77/126), and of the respondents 43.1% (50/116) had been in practice for less than 10 years and 33.6% (39/116) for up to 20 years. Only a quarter (25%) were affiliated to an academic institution. Twenty-four per cent (29/123) of the gynaecologists offered vaginal pessaries as first-line treatment for POP in their clinical practice. With regard to indications for vaginal pessary use, surgical or anaesthetic risk (63.9%, 85/133) and the patient declining surgery (49.6%, 66/133) were the two most common reasons for pessary prescription. The ring pessary was the first choice for 95.8% of respondents (113/118), and it was the commonest pessary used for all prolapsed compartments (anterior/middle/posterior).

Reasons for pessary discontinuation included recurrent involuntary expulsion (51.9%, 69/133), discomfort (41.3%, 55 out of 133), opting for surgery (39.1%, 52/133), and infection (22.6%, 30 out of 133). When asked about the first visit after pessary insertion, 50.5% (53/105) of the respondents said that they would review their patients within 4 - 6 weeks after insertion, and 37.1% (39/105) would do so within the first month.

Of the respondents 45.8% (44/96) routinely followed up their patients at 3 - 6-monthly intervals and 30.2% (29/96) at 6-monthly to annual intervals. Oestrogen cream was routinely prescribed with pessaries by 80.4% (86/107). In order to assess their familiarity with vaginal pessaries, the gynaecologists were asked if they had received any previous formal training and whether they thought that there is a need for a formal training programme. Only 8.2% (9 out of 110) said that they had received formal training, and 74.5% (76/102) thought that there is a need for a training programme.

Discussion

There are limited publications evaluating vaginal pessary use by clinicians, and this study is the first to describe patterns of use among South African gynaecologists. The positive impact of vaginal pessaries on urinary, bowel, sexual and general quality of life has been noted,¹¹ even compared with surgical intervention for symptomatic POP.¹² Recent studies have shown that when pessaries were offered to women with symptomatic POP, the majority opted for initial treatment with pessaries.¹³ Since surgical outcomes are poorly defined and surgery for POP is associated with high re-operation rates,¹⁴⁻¹⁶ it is important for clinicians to be aware of alternative effective modalities of treatment. Furthermore, the finding that symptom improvement with pessary use is comparable to that after surgical intervention may justify use of vaginal pessaries in the armamentarium for POP management, and indicate that they should be routinely offered to all patients.

In contrast to other surveys,⁸⁻¹⁰ this study revealed that only a quarter of South African gynaecologists offer vaginal pessaries to their patients. This might be because of educational differences in the medical curriculum, since use of pessaries for POP is not emphasised in the South African postgraduate programme. The results of this survey also show that most South African gynaecologists received no formal training in the use of pessaries, and that the majority feel the need for a formal training programme (75%). The ring pessary was the commonest pessary chosen (96%, 113/118) regardless of the specific compartment that was affected (anterior, apical or posterior), followed by the Gellhorn and donut pessaries. In the American survey, the ring pessary was the first choice for both anterior and posterior compartmental defects; for the apical compartment, the donut pessary was the commonest chosen.⁸ Reasons why the ring pessary is the commonest chosen by clinicians may be that its simple design makes it more visually appealing than the other pessaries, and the fact that it requires minimal manual dexterity on the part of both patient and clinician. Pott-Grinstein *et al.* have also reported that most gynaecologists perceive the ring pessary to be the most comfortable for patients.⁹

Recurrent involuntary expulsion (51.9%, 69/133), patient discomfort (41.3%, 55/133) and opting for surgery (39.1%, 52/133) were the leading reasons for pessary discontinuation. Less common reasons included vaginal bleeding (17.2%, 23/133) and infection (22.6%, 30/133). These figures are similar to those reported by Gorti *et al.*, who conducted a survey among UK obstetricians and gynaecologists.¹⁰ Their study revealed that recurrent involuntary expulsion (54%), discomfort (27.4%), vaginal bleeding and infection (7.8%), disliking the changing procedure and opting for surgery (10.7%) were the main reasons for patients discontinuing pessary use.

The majority of respondents reviewed their patients within 6 weeks after the initial fitting and thereafter on a 3 - 6-monthly basis. This practice is similar to that of UK gynaecologists,¹⁷ whereas the survey among members of the American urogynaecological society revealed no clear observation interval.⁸ This is confounded by the fact that there are currently no standardised guidelines for clinicians on the use of vaginal pessaries for POP. It appears that most gynaecologists (94% of members of the American urogynaecological society and 80% of South African gynaecologists) favour the use of oestrogen cream.

In view of much positive evidence for pessary use as a treatment option, it is important for all general practice clinicians, nurses and gynaecologists to be familiar with the use of vaginal pessaries for POP. There is a need for more randomised controlled trials with long-term follow-up data comparing vaginal pessary use with surgical intervention to guide clinical practice.

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