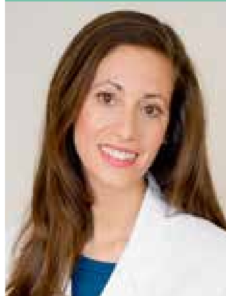

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Pessary use for pelvic organ prolapse in sexually active women

By Brooke M. Faught, MSN, WHNP-BC, IF

Pelvic organ prolapse (POP), a common condition in women, increases in prevalence with advancing age. Treatment for POP may include pelvic floor exercises, surgery, and/or use of pessaries. Pessaries offer women a nonsurgical, cost-effective, low-risk option for treating symptomatic prolapse. This column focuses on what healthcare providers need to know when caring for sexually active women with POP who choose to use a pessary.

Approximately 3% of women in the United States have pelvic organ prolapse (POP).[1] POP prevalence in U.S. women is projected to reach 5% by 2050 because of changing demographics.[2] POP may involve the bladder (cystocele), rectum (rectocele), small bowel (enterocele), urethra (urethrocele), and/or uterus (uterovaginal prolapse). Although many women with POP remain asymptomatic, some report vaginal pressure, sensation of a vaginal bulge, vulvovaginal irritation, bowel or bladder dysfunction, and/or a disruption in sexual functioning. Healthcare providers (HCPs) should perform a pelvic examination on all patients with known or suspected prolapse and document the type and stage of prolapse.[3] The POP quantification system (POP-Q) is commonly used to stage the condition.[4]

A nonsurgical alternative

Not all women with POP are surgical candidates. And even among those who are candidates, many prefer to avoid surgery for a variety of reasons. These women may

benefit from a nonsurgical treatment that is effective and that poses minimal risk: a pessary.[3] A pessary is a soft-yet-firm, medical-grade silicone device that comes in various sizes and shapes and that is placed in the vagina to support the prolapsed area. Up to 90% of women with POP can be successfully fitted for a pessary.[5] The pessary shape recommended for an individual woman depends on the type, location, and severity of prolapse, as well as the presence or absence of stress urinary incontinence. The most frequently used pessary shapes for women with POP are the ring, oval, donut, Shaatz, and dish. Less commonly used shapes for this indication are the Gehrung, Mar-Land, Hodge, and cube.

Special considerations for sexually active women

When HCPs consider prescribing a pessary for a sexually active woman, they need to ascertain the types and frequency of sexual activity in which the woman is engaging. Most pessaries must be removed before penetrative sex play (e.g., intercourse, use of sexual aids or toys inserted within the vagina); HCPs should know that the ring, oval, and Shaatz pessaries are easiest for a patient to self-manage. At the time of the pessary fitting, the HCP should teach the patient how to remove and replace the pessary so that it does not interfere with sex play. At this

same visit, the patient should demonstrate to her HCP that she has learned the proper techniques. A woman who finds that she is not capable of pessary self-maintenance may opt for nonpenetrative sex play or have her partner learn to remove and replace the pessary. Another option is for the HCP to remove the pessary before a planned penetrative event (e.g., during a trip or vacation). The woman may then return at a later date for pessary replacement. This option is particularly suitable for a woman with mild prolapse who infrequently partakes in penetrative sex play.

Many postmenopausal women experience urogenital tissue changes related to vulvovaginal atrophy (VVA).[6] If VVA is suspected during a pessary fitting, HCPs should consider prescribing treatment with local vaginal estrogen or other FDA-approved products for VVA symptoms. This treatment may prevent vaginal tissue breakdown while the pessary is being worn, as well as potentially improve other manifestations of VVA, including dyspareunia and vaginal dryness.[7-11] All pessary users, but particularly those with VVA, should be encouraged to use a water-based, glycerin-free lubricant with removal and replacement of the pessary.

Some women may complain of vaginal odor and discharge with prolonged pessary use. Presence of ejaculate in the vagina may increase the potential for a temporary shift in vaginal pH. Women who engage in sexual activity that involves internal ejaculation may want to douche with a diluted hydrogen peroxide solution *before* replacing the pessary. Although postcoital douching is not necessary, many women report that this practice diminishes vaginal discharge and odor. Over-the-counter, prepared douche solutions are not advised because of the presence of harsh ingredients that may disrupt the normal vaginal ecosystem.

Conclusion

Pessaries are a suitable alternative to more invasive and expensive treatments for symptomatic POP. HCPs should assess women's sexual health history at the time of the pessary fitting in order to preserve their desired type and frequency of sexual activity. Additional thoughts when considering a pessary include the presence of bowel and bladder dysfunction, VVA, and tendency for vaginal discharge and odor.

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