As part of the nursing assessment of patients in women’s health clinics, women are asked if they experience symptoms of urinary incontinence (UI) or pelvic organ prolapse (POP). With the myriad of information available to women today to help them manage health-related issues, nurses who initially assess these women should pursue this aspect of care beyond handing patients a sheet of paper with instructions for performing pelvic floor (Kegel) exercises. Urogynecology nursing, continence nursing, and the use of vaginal pessaries are relatively new to nurses in Canada. Interested nurses could make a valuable contribution through research and clinical practice to the limited knowledge in this field.

Historical Review

Pessaries have existed in one form or another for centuries (Alnaif & Drutz, 2000; Bash, 2000; Cundiff, Weidner, Visco, Bump, & Addison, 2000; Deger, Menzin, & Mikuta, 1993; Moore & Paul, 1997). Viera and Larkin-Pettigrew (2000, p. 2719) stated that the pessary is one of the “oldest medical devices available,” and Flood and Hanson (2003, p. 289) confirmed that “pessaries are some of the oldest known medical devices.” Cundiff et al. (2000, p. 931) stated that “the use of pessaries for pelvic organ prolapse can be traced to antiquity.” Cundiff et al. (2000) also provided a concise one-paragraph synopsis of the treatment of pelvic organ prolapse using vaginal pessaries from the mid 1800s to the present, stressing that complications related to its use and the advances in surgical techniques to repair prolapse resulted in its decline from common practice for many years. Miller (1991) provided an informative history of the pessary with written reports of its use by Aurelius Cornelius Celsus in De Medicina as far back as 27 BC, and Deger et al. (1993) dated the first recorded description of prolapse to a piece of papyrus presumed to have been written in 1500 BC. These references to the existence of the pessary refer to its use as a support device for pelvic organ prolapse. In these two articles the history, indications, types, care, and complications of pessary use that have been recorded since antiquity were well described.

Palumbo (2000) stated that the use of vaginal pessaries for urinary incontinence (UI) is a relatively new treatment option, having been discovered by accident when women realized that they leaked less urine when exercising with a vaginal tampon in place. However, Wall (2003) cited references to the early 19th century describing the use of pessaries to treat stress urinary incontinence. Most authors, even those whose primary concern was for the use of pessaries for managing genital prolapse, also mentioned their use for treating UI, if only in passing.

Epidemiology and Etiology

All authors, except those presenting case studies, reviewed and discussed to some extent the prevalence and causes of pelvic
organ prolapse and/or UI. Although most commonly found in multiparous women, uterine prolapse occurs in nearly 2% of nulliparous North American women (Fritzinger, Newman, & Dinkin, 1997). It was generally agreed that the prevalence of genital prolapse increases as women age (Deger et al., 1993; Hanson, Schulz, Flood, Cooley, & Tam, 2003; Heit et al., 2003; Poma, 2000; Romanzi, 2002; Schulz, 2001) and can be caused by childbirth, by factors that chronically increase intra-abdominal pressure (coughing, sneezing, or heavy lifting), weakened pelvic supports, and inappropriate corrective surgery (Viera & Larkins-Pettigrew, 2000). In addition, Jackson and Smith (1997) briefly described some of the causes of genitourinary prolapse as long labor, assisted delivery, large babies, poor postnatal exercise programs, connective tissue diseases, hysterectomy, obesity, chronic respiratory diseases, and pelvic masses. Schulz (2001) added that race, anatomy, connective tissue and neurologic conditions may also contribute to the development of incontinence and pelvic floor prolapse. “With the depletion of estrogen at the time of menopause, the changes of urogenital aging include a decrease in collagen content and atrophic changes in the tissues of the pelvic floor. This estrogen loss also contributes to the development of pelvic floor problems, especially in pelvises already damaged by the effects of childbirth” (Schultz, 2001, p. 55).

Poma (2000, p. 798) defined genital prolapse as “the protrusion or projection of pelvic organs into the vagina or outside the vagina.” Poma (2000) as well as Jackson and Smith (1997) categorized the following as possible symptoms of genitourinary prolapse:

- Difficulty emptying the bladder or bowels
- Urgency
- Hesitancy
- Urge incontinence
- Sexual discomfort
- Inability to reach an orgasm
- Incontinence during sexual activity
- Vaginal feelings of heaviness or pressure
- Vaginal or perineal pain
- Low back pain
- Abdominal pressure or pain
- Difficulty walking due to a protrusion from the vagina
- Difficulty inserting or keeping a tampon in place
- Vaginal-cervical mucosa hypertrophy, excoriation, ulceration, and bleeding

Schulz (2001) presented a concise etiology of pelvic organ prolapse as caused by intrinsic factors (race, anatomy, connective tissue, and neurologic conditions) and extrinsic factors (effects of menopause, childbirth, pelvic surgeries, pelvic trauma, and anything that increases intra-abdominal pressure). “Caucasian women have a higher prevalence of pelvic floor problems; whereas, African and Asian women seem to be relatively unaffected” (Schulz, 2001, p. 55).

Romanzi (2002) estimated that the cost of surgical management of genital prolapse has surpassed $10 billion annually in the United States alone. Thompson and Smith (2002) estimated that the cost of managing UI in persons aged greater than 65 years is $26 billion in the United States annually.

Scientific Review

Research articles. Nine research articles were reviewed (five from Canada, two from the United States, one from England, and one from The Netherlands). Three addressed the use of the pessary for treating stress UI (Farrell, 2004; Mokrzycki, Hatangadi, Zaccardi, & Cox, 2001; Robert & Mainprize, 2002), and six addressed their use for management of pelvic organ prolapse (Alnaif & Drutz, 2000; Arabin, Halbesma, Vork, Hubener, & vanEeck, 2003; Hands & Jones, 2002; Heit et al., 2003; Singh & Reid, 2001; Wu, Farrell, Baskett, & Flowerdew, 1997). One of these five studies examined the use of pessaries in pregnant women with uterine prolapse (Arabin et al., 2003). The general consensus reached by these authors was that there were definite benefits to the use of pessaries for both stress UI and pelvic organ prolapse. Prolapse was unlikely to worsen during the use of a supportive device (Handa & Jones, 2002), and there was not one documented case of a woman losing her life as a result of the use, or even the abuse of a vaginal pessary (Deger et al., 1993). Two articles (Mokrzycki et al., 2001; Wu et al., 1997) presented evidence that if patients had pre-existing stress UI, they had a higher risk of failed pessary use for genital prolapse because the benefits of pessary use for genital prolapse were outweighed by the inconvenience of increased UI unless the pessary selected also helped to manage the urinary incontinence.

Case studies. Four case studies were reviewed (Chow, LaSalle, & Rosenberg, 1997; Kankam & Geraghty, 2002; Roberge, McCandlish, Dorfman, 1999; Sasso, 2003). These are useful in elucidating some of the more complicated and atypical problems that result from pessary use such as vesicovaginal fistulas from erosion of a pessary, obstruction of the urinary tract, erosion of a pessary through the upper rectum, or colonization by bacteria. They do not, however, enumerate the most common problems experienced by pessary wearers such as vaginal discharge and odor, pelvic pain, bleeding, development of UI, failure to retain a pessary in the vagina, failure of the pessary to hold the prolapse properly within the vagina, or erosions of the vaginal wall. Chow et al. (1997) described the development of UI secondary to pessary use.

Pelvic Anatomy

tioning and support systems of the pelvis. Farrell (2004), Poma (2000), and Kimmons (2003) elucidated how genital prolapse is described using a standard nomenclature and a fixed point of reference within the vagina for measuring the degree of prolapse. This description of the pelvic organ prolapse quantification system (POP-Q) is useful to nurses wishing to make measurable and verifiable documentation of pelvic organ descent using such terms as “anterior vaginal wall prolapse” and “posterior vaginal wall prolapse” instead of words like “cystocele” and “rectocele,” as these two words assume that the contents of the herniated vaginal wall contain bladder and bowel (Bump, Mattiasson, & Bo, 1996).

Davila (1996) described clearly the development of stress UI from an anatomical point of view. Jackson and Smith (1997) included good diagrams to support their description of the pelvic organ support system. Palumbo (2000) and Viera and Larkins-Pettigrew (2000) described a much more subjective method of measurement using words such as “first degree,” “second degree,” “third degree,” and “fourth degree” to relate the extent to which the prolapse protrudes past the hymenal ring. This method of measurement is subjective to the examiner’s own definitions of the words “mild,” “mild-to-moderate,” and “moderate,” and does not provide for accurate verification by a second examiner. Jackson and Smith (1997) recommended using the parameters set out by the International Continence Society in assessing pelvic organ prolapse (Bump et al., 1996; Hall, Theofrastous, & Cundiff, 1996).

Definitions

Where pessaries were described in the literature, the general consensus was that they are primarily used as vaginal prostheses for the conservative and nonsurgical management of uterine prolapse and cystoceles, rectoceles, enteroceles, procidentia, and in managing stress urinary incontinence (Bash, 2000; Viera & Larkins-Pettigrew, 2000). Pessaries were most often described as round devices of various shapes and sizes that hold the prolapse inside the vagina (Davila, 1996). They provide support to related pelvic structures and can alleviate UI.

Pessaries have been manufactured from silicone, rubber, clear plastic, and soft plastic, some with internal moldable steel reinforcements (Poma, 2000). Currently most pessaries are made of silicone that is considered nonallergic, does not absorb odors or secretions, is resistant to breakdown with repeated cleansing and autoclaving, and is soft and pliable (Bash, 2000). Poma (2000) mentioned latex pessaries; however, he stated that they are no longer popular because some women have allergies to latex that can range from mild skin irritation to asthma and anaphylaxis.

Viera and Larkins-Pettigrew (2000) classified uterine prolapse as either first-degree, where “the cervix is visible when the perineum is depressed,” second-degree, where “the cervix is visible outside of the vaginal introitus, while the uterine fundus remains inside,” and third-degree prolapse, or procidentia, where “the entire uterus is outside of the vaginal introitus.” They stated that “uterine prolapse is associated with incontinence, vaginitis, cystitis and, possibly, uterine malignancy.” They described “variants of vaginal prolapse [as including] rectocele, enterocele, cystocele and vault prolapse” (Viera & Larkins-Pettigrew, 2000, p. 2720).

Clinical Implications

Indications for pessary use.

All the authors reviewed listed one or several indications for pessary use, including support for vaginal prolapse (Flood & Hanson, 2003; Sulak, Kuehl, & Shull, 1993; Thompson & Smith, 2002; Viera & Larkins-Pettigrew, 2000), poor operative risk patients (Miller, 1991), and the use of pessaries in treating patients with a short cervix before 28 weeks gestation (Arabin et al., 2003). In addition to its usefulness as a temporary or permanent alternative to surgery for some patients, Bash (2000), Flood and Hanson (2003), Poma (2000) also mentioned the benefits of pessary use in facilitating preoperative healing of vaginal and cervical ulcers, improving UI, uncovering latent stress incontinence before surgical repair of genital prolapse, and predicting whether surgery will correct problems such as pelvic and back pain which may be due to prolapse. Several authors mentioned its usefulness in pregnancy and uterine retroversion (Arabin et al., 2003; Flood & Hanson, 2003; Smale, Smale, Del Mundo, & Rivera, 1997).

Myers, LaSala, and Murphy (1998, p. 1019) described the use of double pessaries (either a donut or Inflataball with a second pessary such as a Gelhorn or Shaatz (Milex Products, Inc.) in cases of severe prolapse where “the vagina cannot retain a single pessary.” Singh and Reid (2001, p. 112) described the use of double ring pessaries in patients “with advanced prolapse who were unsuitable for surgical correction and in whom single ring pessaries previously had failed.” Cundiff et al. (2000) shed light on the reasons why many physicians do not use pessaries more frequently as a first-line of therapy for every woman with genital prolapse. In their research into the trends in pessary use for pelvic organ prolapse, 12% of the 359 respondents surveyed responded that they “reserve pessaries for a subset of patients who either decline surgery or are not surgical candidates” (Cundiff et al., 2000, p. 931). They also concluded that if a patient had previous pelvic surgery, the probability of a successful pessary fitting was reduced. This reluctance to use pessaries as a first line of conservative therapy may stem from the belief that “pessaries are perceived to be inconvenient for both the physician...
and the patient” (Wu et al., 1997, p. 990).

In a literature review conducted by Farrell (2001, p. 1188), it was determined that pessaries used for incontinence offered “a safe and highly effective treatment for stress urinary incontinence.” This conclusion was also reached by Flood and Hanson (2003), Newman and Burns (1997), and Robert and Mainprize (2002). Bash (2000, p. 455) mentioned the use of pessaries “in the management of neonatal prolapse which often occurs in conjunction with neural tube defects.” Flood and Hanson (2003, p. 290) stated that pessaries “may alleviate stress and urge incontinence by elevating the bladder neck” and they can “help predict whether urge incontinence will be relieved after surgery” (Flood & Hanson, 2003, p. 290).

Types of pessaries. Nine of the authors described the different types of pessaries used to treat UI and genital prolapse. Some (Bash, 2000; Davila, 1996; Deger et al., 1993; Fritzinger et al., 1997; Flood & Hanson, 2003; Miller, 1991; Viera & Larkins-Pettigrew, 2000) provide detailed descriptions with diagrams and pictures of the different styles of pessaries used to support various degrees of genital prolapse. In two separate articles, Farrell (2001, 2004) described the use of the incontinence ring and incontinence dish pessaries. In another article, Farrell (1997) described and illustrated the use of the ring pessary. These are the most basic types of pessaries and the ones usually tried first. If the prolapse or incontinence is not resolved with one of these two types of pessaries, other styles such as the Gellhorn, Gehrung, Shaatz, donuts, or cubes may be tried.

Poma (2000) mentioned briefly the different models of pessaries manufactured by one company in the United States, but the author did not elucidate on their use for particular types of prolapse. Hanson et al. (2003) gave specific success rates in percentages for the different styles of pessaries they used in their study, based on their criteria for measuring success which was patient comfort, proper fit, and relief of symptoms.

Patient assessment. All authors who addressed this topic agreed that individual assessment of patients presenting with pelvic organ prolapse and/or urinary incontinence should first include a thorough history and a physical examination. Jackson and Smith (1997) provide good diagrams to augment their detailed description of the clinical bimanual examination of the patient, both in a standing position to reproduce the conditions under which the prolapse occurs, and using a Sims speculum in a supine position. Heit et al. (2003) concluded that age, prior pelvic surgery, pelvic pain or discomfort associated with prolapse, and degree of prolapse are all important considerations for patients considering the use of a pessary. These authors also concluded that the older the patient, the more likely she was to opt for pessary use over surgery. In addition, they found that patients who had previously undergone prolapse surgery were more likely to opt for surgery again. This was unexpected, as failed previous surgery would lead one to believe that patients would not choose this option more than once.

According to Farrell (2001), the physical assessment of patients with UI should include a urinalysis and urine culture, visualization of urine loss with a stress test, assessment of pelvic muscle strength, and the measurement of post-void urine volume (see Table 1). In addition to physical assessment, subjective factors such as urinary symptoms of hesitancy or prolonged urine stream, urine leakage during exercise or other physical activities or occupations, feelings of incomplete emptying, bowel symptoms of difficulty defecating, and sexual symptoms such as dyspareunia and incontinence during sexual intercourse should be assessed by questioning the patient (Poma, 2000) (see Table 2).

When the symptoms and signs of prolapse do not correlate (for example, if a patient reports the feelings of prolapse but no prolapse is evident on physical examination), Thakar and Stanton (2002) recommended using urodynamic studies and pelvic fluoroscopy with barium contrast to further diagnose the cause of the symptoms.

Pessary fitting. Several authors provided details of pes-

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Table 1. Physical Assessment of Patients with Urinary Incontinence

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<th>Measurements</th>
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<td>Urinalysis</td>
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<td>Urine culture</td>
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<td>Visualization of urine loss with a stress test</td>
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<tr>
<td>Measurement of post-void urine volume</td>
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<td>Assessment of pelvic muscle strength</td>
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Table 2. Subjective Assessment of Patients with Urinary Incontinence

<table>
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<th>Symptoms</th>
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<tr>
<td>Urinary symptoms of hesitancy</td>
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<td>Urinary symptoms of prolonged urine stream</td>
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<tr>
<td>Urine leakage during exercise or other physical activities or occupations</td>
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<tr>
<td>Symptoms of incomplete emptying of bladder</td>
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<tr>
<td>Difficulty defecating or incomplete emptying of the bowels</td>
</tr>
<tr>
<td>Dyspareunia</td>
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<tr>
<td>Incontinence during sexual intercourse</td>
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Pessary placement and fitting (Bash, 2000; Farrell, 1997, 2004; Flood & Hanson, 2003; Palumbo, 2000; Thakar & Stanton, 2002), and all provided diagrams except Palumbo. While pessary manufacturers provide suggestions for different pessary styles to manage different types of prolapse, the experienced clinician knows that trial and error is really the only way to determine the best fit for each patient and depends on a number of factors such as the location and severity of the prolapse, the symptoms associated with the prolapse, the patient's physical capacity and willingness to participate in the care of the pessary, the size of the introitus, the patient's weight and her physical activity (Bash, 2000; Farrell, 1997; Miller, 1991; Viera & Larkins-Pettigrew, 2000). Thakar and Stanton (2002, p. 324) stated, "there is a lack of good data on the indications for different types of pessaries."

All authors who discussed pessary fitting agreed that it often requires a trial of several different styles and sizes of pessaries to find one that is not too loose and thus expelled when the patient strains or walks, is comfortable and not felt by the patient when in place, is not too tight so as to increase the risk of vaginal abrasions, allows the patient to void without difficulty, and can be removed easily and re-inserted by the patient with teaching. The greater the size of the introitus, the more difficult the fitting as pessaries tend to be easily expelled when the vaginal opening is large. As well, women with a shortened vagina as a result of previous hysterectomy are more difficult to successfully fit, as the vaginal length is sometimes markedly shortened and the pessary cannot be easily secured behind the pubic bone. Farrell (2004, p. 116) concluded that "presenting symptoms did not affect the success of pessary fitting" when he referred to the presenting symptoms of UI and not pelvic organ prolapse.

Routine care. Fritzinger et al. (1997) stated that there is no scientific data outlining the standards of care for users of vaginal pessaries. However, most authors agreed that routine followup care of pessaries is necessary to minimize the risk of complications associated with its use. Once a pessary has been fit, the patient should ambulate and urinate with the pessary in place before leaving the clinician’s office (Deger et al., 1993). After the initial fitting, the patient should return after a 1 to 2 week interval for re-assessment (Farrell, 1997; Fritzinger et al., 1997). Depending on the style of pessary, if the patient is satisfied and the prolapse is reduced to her satisfaction, she should return every 6 weeks to 3 months, and sooner if the pessary falls out or she develops leukorrhea, vaginal bleeding, pelvic or abdominal pain, or urinary or bowel retention (Fritzinger et al., 1997; Palumbo, 2000). At each visit for re-assessment, the pessary should be removed and cleaned using mild antibacterial soap and warm water. It should be examined to ensure that the integrity of the silicone is intact and that it has not become brittle (Viera & Larkins-Pettigrew, 2000). Farrell (1997) was the only author to describe pessary removal in detail.

Over time, the pessary style or size may have to be changed, but with proper care, a silicone pessary should last from 1 to 2 years. At each followup visit the vaginal mucosa should be examined both laterally and anteriorly/posteriorly using a Sims or bivalve speculum (Farrell, 2000; Viera & Larkins-Pettigrew, 2000). Silicone pessaries can be sterilized using cold sterilization, boiling or autoclaving, but the manufacturer’s recommendations should be followed for this (Deger et al., 1993). Viera et al. (2000) recommended the use of a vaginal douche using dilute vinegar or hydrogen peroxide for relief or minor vaginal irritation or itching. Bash (2000) stated the ideal care is for the patient to remove the pessary nightly and wash it with soap and water, reinserting it in the morning. She says that the next best alternative is to remove it overnight once a week. This implies, of course, that the patient has been taught how to manage her own pessary. However, Bash (2000) does not address this in her article.

Deger et al. (1993, p. 5) stated that “coitus is unaffected by pessaries lacking a barrier or support.” Patients should be advised that intercourse may be possible, but that the couple should be aware that the presence of the pessary could cause discomfort and therefore sexual activity should be undertaken with caution until the couple is comfortable with the presence of the pessary, or the pessary should be removed prior to intercourse.

Complications associated with pessary use. Several authors discussed complications, either by describing one or several case studies (Chow et al., 1997; Duncan, Foltzer, & O’Hearn, 1997; Flood & Hanson, 2003; Fritzinger et al., 1997; Kankam & Geraghty, 2002; Roberge et al., 1999; Sasso, 2003), or by listing the most commonly occurring complications and their treatment. Even though the pessary is “an extremely safe device, it is still a foreign body in the vagina” (Viera & Larkins-Pettigrew, 2000, p. 2725). All authors listed vaginal discharge and odor as the most common form of complication. The treatment recommendation for this was the regular use of an acidic vaginal gel (Viera & Larkins-Pettigrew, 2000), good vaginal hygiene, the use of estrogen cream, and the use of antibiotics as indicated (Alnaif & Drutz, 2000; Bash, 2000). Flood and Hanson (2003, p. 296) stated that “Trimo-San gel (Milex Products Inc.) inserted twice weekly into the vagina at night can help keep odor to a minimum.” Other difficulties such as pelvic pain, bleeding, development of UI, failure to retain a pessary in the vagina, or failure of the pessary to hold the prolapse properly within the vagina were reported as complications associated with pessary use (Farrell, 2000).
pelvic organ support, they had a negative impact on urethral function and UI. Flood and Hanson (2003, p. 293) succinctly summarized the use of estrogen replacement when they stated: “the perimenopausal and postmenopausal woman should be on some form of estrogen replacement if they are to wear a pessary.” They also said “the added vaginal lubrication eases fitting and removal of the device. Estrogen also thickens the vaginal wall, increases elasticity and prevents erosions” (Flood & Hanson, 2003, p. 293). The importance of preparing the vagina for pessary fitting by prescribing vaginal estrogen cream for use before or concurrently with pessary fitting was also stressed by Viera and Larkins-Pettigrew (2000), Deger et al. (1993), Bash (2000), and Kimmons (2003). In Poma’s (2000) discussion of a prospective study conducted by Wu et al. (1997) of women fitted with a pessary, he stated that hormonal use did not relate to the success of pessary use. Jackson and Smith (1997, p. 878) agreed that “postmenopausal estrogen supplementation increases skin collagen content and causes trophic alterations in vaginal epithelium. Whether hormone replacement therapy increases the biomechanical strength of tissue or prevents the occurrence of genitourinary prolapse is unclear.”

Alternatives to Pessary Use

Eight authors described alternatives to pessary use for pelvic organ prolapse (Farrell, 2001; Flood & Hanson, 2003; Jackson & Smith, 1997; Kimmons, 2003; Newman & Burns, 1997; Nygaard, 1995; Potera, 1996). Suggested alternatives were the use of urinary control pads, urethral occlusion inserts, bladder neck prostheses, tampons, intravaginal weights, biofeedback for pelvic floor rehabilitation, pelvic floor exercises, and pharmacologic therapy. In five articles (Flood & Hanson, 2003; Jackson & Smith, 1997; Nygaard, 1995; Potera, 1996; Thakar & Stanton, 2002) the focus was on alternative treatments for pelvic organ prolapse such as the use of a tampon inserted into the vagina for short periods of time during exercise, surgery, prevention such as better management of prolonged labor, hormone replacement therapy, pelvic exercises, weight loss in obese patients, and management of chronic coughs.

Nurses’ Roles

Flood and Hanson (2003, p. 292) stated that “a centralized, nurse-run clinic is an ideal solution” to the problem of most facilities not being able to offer a wide range of pessaries to suit all patients’ needs. Hanson et al. (2003) stated that “advance practice nurses such as nurse continence advisors need to acquire the skills to assess POP and UI. They should also learn the indications for pessary use and how to properly fit and care for vaginal pessaries. This conservative management option should be readily available to women who are looking for an alternative to a surgical intervention.” Palumbo (2000, p. 40) stated that “nurses’ roles regarding pessary use need to be clearly defined.” This includes the nurses’ understanding of the indications for their use; the types available and the skills necessary to assess prolapse; the expertise to safely fit, insert, and remove pessaries; and the ability to identify and recommend appropriate treatment for the signs and symptoms of problems. It is not surprising that
most of the articles reviewed did not refer to the role of the nurse in the care of these patients, as physicians wrote many of the articles for other physicians. Thakar and Stanton (2002) mentioned a multidisciplinary team approach that included urologists, gynecologists, and colorectal surgeons but did not include nurses as part of their team.

**Patient Teaching**

Palumbo (2000, p. 43) stated, “patient education is vital for successful pessary use.” She recommended reviewing the female anatomy with the patient by using diagrams to show both the normal and prolapsed placement of pelvic organs. One of the cornerstones of nursing practice is patient education and informed consent. To this end, nurses should always be looking for ways to help patients actively take part in their self-care, and this is especially important in pessary management, as it helps ensure longer patient compliance and reduce the risk of complications.

**Conclusions**

The use of pessaries to manage genital prolapse and urinary incontinence has been documented since antiquity. Pessary use has come in and out of fashion depending on the current thinking in the medical community about the most effective management of these conditions by surgical intervention or conservative management. The cost of surgery to manage pelvic organ prolapse continues to escalate. The nurse’s role has always been to follow the physician’s recommendations for treatment. His/her role in the assessment of patients for pessary suitability, pessary fitting and follow-up, teaching pessary self-care, and recognition of signs and symptoms of problems arising from pessary use are not well documented in the literature. Except for the few articles written by nurses on this topic, there was no mention in the medical literature of the role of the nurse in educating patients in their care and self-management. This is not surprising as there is no reason for physicians to make recommendations on nursing practice.

The historical origins of the pessary were interestingly presented in the literature and several authors succinctly summarized the epidemiology and etiology of its use. Many of the authors did not rank pessaries highly in the hierarchy of first-line management of women with both stress UI and pelvic organ prolapse, confining them instead to an option to be considered only when surgical intervention had been ruled out. The indications for pessary use and patient assessment are well documented, and are the types of pessaries available and the complications associated with their use. Few authors provided details on pessary fitting and routine care. Whether estrogen therapy plays a role in helping prevent vaginal abrasions and erosions is still not clear. Alternatives to pessary use for managing stress UI have been better researched and documented than the alternatives for pelvic organ prolapse, except for surgery. Nurses have been trained to use a holistic framework when assessing patients. As such nurses can play an important role in counseling women about their options for pessary treatment. Many women do not cope well with the thought of manipulating a vaginal device or with the tedious routine of care for a pessary. Some women are not cognitively able to understand the importance of vaginal hygiene or attention to the sometimes subtle changes in vaginal discharge. Some are not functionally capable of managing a pessary themselves due to restricted mobility, obesity, or arthritic conditions. Nurses must be able to pick up these subtle hints to help them assess the patient’s suitability for pessary use. The nurse will develop credibility in her practice by using standardized nomenclature in describing pelvic organ descent, as this provides a measurable and duplicatable frame of reference.

Interested nurses will find many areas where more research is needed, such as the effects, both positive and negative, of estrogen in preparing the vagina to receive a pessary. Presentations of case studies are an interesting way for nurses to share information about the potential problems of pessary use and their solutions. Nursing clinics devoted to the assessment, fitting, and followup of vaginal pessaries are highly effective and cost saving.

It is clear from this literature review that interested nurses could make a valuable contribution to the bank of information available in the use of vaginal pessaries to treat stress urinary incontinence are pelvic organ prolapse.

**References**


