



Pessary self-management: A national survey of urogynaecologists in the United Kingdom

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ABSTRACT

This project aims to evaluate the obstacles, as viewed by specialists affiliated to the British Society of Urogynaecology (BSUG), in implementing pessary self-management for women with pelvic organ prolapse. A 7-item survey was sent to 466 members of BSUG by e-mail. Data were collected on unit demographics and obstacles to the wider adoption of self-management of pessaries. We received 88 responses. Of those, 15/88 respondents (16.9%) did not have an urogynaecology nurse and 13/88 (14.8%) had no regular nurse-led pessary clinic. However, 47/88 (53%) stated that they see at least 3 patients who are suitable for pessary self-management per week, but only 39/88 (44%) offer self-management tuition for more than half of their suitable patients. Pessary self-management was more likely to be offered to at least 20% of eligible patients in units with 3 or more urogynaecology nurses compared to units with none (16/22 versus 5/15, $p=0.0176$) and in units with a regular nurse led clinic compared to those without (47/75 vs. 4/13, $p=0.031$). The top three challenges in expanding pessary self-management tuition were: Lack of human resources, lack of patient engagement or suitability and lack of clinic time. The majority stated that main barriers could be overcome with adequate clinic time to address patient concerns and encourage them to try changing their own pessary. A significant number of patients who are suitable for pessary self-management are currently receiving clinic-based care. Research is necessary to further evaluate the cultural and organisational barriers to wider utilisation of self-management of pessaries.

Keywords: Pessary self-management; pelvic organ prolapse; cystocele

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INTRODUCTION

Pelvic organ prolapse (POP) is a common condition that can cause distress and negatively affect the quality of life of women. The prevalence of POP varies world-wide. The International Urogynaecology Association published a consultation paper in 2023 quoting a 1-65% prevalence rate, based on symptoms (1-31%), pelvic examination (10-50%), or both (20-65%).¹ POP can be managed conservatively or surgically. Interest in conservative management has increased subsequent to the widely publicised complications of mesh prolapse repair. One of the conservative treatment options available for POP is the use of a vaginal pessary to support the prolapse. The pessary helps to restore prolapsed organs to their natural position with the aim to relieve associated symptoms. Vaginal pessaries are typically fitted by a healthcare professional in an outpatient clinic setting. Patients will then return every 4-6 months for a review and have the pessary renewed. This is referred to as clinic-based pessary management. Having to attend regular clinic appointments can be inconvenient for the women and it can be a reason women opt for surgical management of POP.² Other reasons for pessary discontinuation include side-effects such as vaginal discharge.^{2,3} A proportion of prolapse sufferers end up having an operation for their prolapse. The life-time risk of undergoing surgery for POP in the UK is 9.5%.⁴

The alternative to clinic-based pessary management is pessary self-management, in which women are taught how to remove, clean and reinsert the pessary themselves. This allows the women to manage their condition in a way that best suits their lifestyle. The treatment of prolapse with self-care pessary (TOPSY) trial demonstrated that self-management of vaginal pessaries for prolapse is not only feasible and cost-effective but also associated with fewer complications.⁵ By reducing the number of patients attending the clinic for routine pessary changes. Outpatient clinic capacity is increased to accommodate new referrals, and healthcare resources are utilised more efficiently. Pessary self-management also has the potential of a lower carbon footprint for the service. However, the implementation of pessary self-management is still not widely adopted in the United Kingdom (UK) and many other countries. This project aims to understand the organisational set up of urogynaecology departments in the

UK and evaluate the obstacles, as viewed by the British Society of Urogynaecology (BSUG) specialists, in implementing pessary self-management for patients with pelvic organ prolapse.

MATERIALS AND METHODS

The survey was conducted in the UK in 2023. A total of 466 members of BSUG were contacted by e-mail by the BSUG secretary and asked to complete a 7-item survey. Data were collected on unit demographics, including the number of urogynaecologists, the number of urogynaecology nurses and the availability of a regular nurse-led pessary clinic in the unit. The survey also aimed to identify the number of patients who were suitable for pessary self-management being seen in the clinic per week and whether pessary self-management tuition was being offered to those suitable patients. Participants were asked about the obstacles in their unit to widen the implementation of pessary self-management. Free-text comments were invited to further understand the opinions of the BSUG specialists regarding pessary self-management.

Statistical Analysis

Data were analysed using SPSS version 15.0 for Windows software (SPSS, Chicago, IL, USA). Quantitative data were presented as ratios and percentages, and analysed using the chi-squared test to test for associations between demographics and responses. The free-text section was analysed using a Framework Approach.⁶ A significance level of $p < 0.05$ was considered statistically significant.

RESULTS

Eighty-eight responses were received and evaluated. The Table 1 summarises the baseline characteristics of the units from which the specialists responded. Among the 88 responses received, 4 (4.5%) of them did not have a urogynaecologist in their unit and 15/88 (17.1%) of them did not have a urogynaecology specialist nurse in their unit. Of the 88 respondents, 46 (52.3%) had more than three urogynaecologists in their units, whereas 22/88 (25.0%) had more than three urogynaecology specialist nurses in their units. A total of 75/88 (85.2%) respondents had a regular nurse-led clinic in their unit and 13/88 (14.8%) did not have a regular nurse-led clinic.

Table 1. Number of urogynaecologists and urogynaecology specialist nurses in the unit

	Number of urogynaecologist in the unit	Number of urogynaecology specialist nurses in the unit
None	4 (4.5%)	15 (17.1%)
One	11 (12.5%)	23 (26.1%)
Two	27 (30.7%)	28 (31.8%)
More than three	46 (52.3%)	22 (25.0%)

Among the 88 responses received, 100% of respondents reported seeing at least one patient who is suitable for pessary self-management per week in the clinic and up to 47/88 (53%) stated that they see at least 3 of those patients per week. Only 39/88 (44%) of the respondents' units offered pessary self-management tuition to more than half of their suitable patients. Some units did not offer self-management tuition to their patients at all: 11/88 (12.5%), Figure 1. In our endeavour to study factors that affect whether a unit offers pessary self-management tuition regularly or not, we studied three factors: Number of urogynaecologists, number of urogynaecology nurses and whether there was a nurse-led pessary clinic. The numbers were too small for a multivariable analysis, so we performed a comparative analysis of variables where the numbers allowed a comparison. Four respondents had no urogynaecologist in their units and 6 respondents had more than four urogynaecologist in their units. Regarding the number of urogynaecology specialist nurses, in units with three or more urogynaecology nurses, 16/22 offered pessary self-management to at least 20% of their patients. In comparison, only 5/15 of units with no urogynaecology nurses offered pessary self-management to at least 20% of their patients [$\chi^2(1, n=88)=5.64, p=0.0176$]. Regarding the presence or absence of a nurse-led pessary clinic, 47/75 of the respondents who had a regular nurse led pessary clinic, offered pessary self-management to at least 20% of their patients, compared to only 4/13 respondents who did not have a regular nurse led pessary clinic in their unit [$\chi^2(1, n=88)=4.62, p=0.031$].

The top three challenges in expanding pessary self-management tuition for patients as reported by our respondents were lack of human resources 52/88 (59%), lack of patient engagement or suitability 49/88 (56%) and lack of clinic time 44/88 (50%), Figure 2. The lack of human resources mainly referred to practitioners who can deliver pessary self-management tuition to patients.

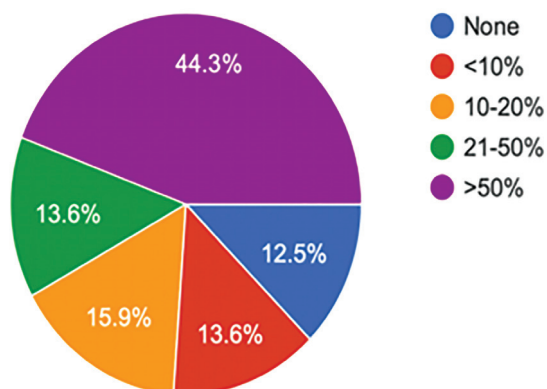


Figure 1. The percentage of patients under your care who are suitable for pessary self-management, being offered pessary self-management tuition

There were 40 free-text comments received. Most of the clinicians were concerned about the suitability of pessary self-management for patients of a certain age group, especially elderly patients with limited manual dexterity and physical fitness. Respondents felt that the idea of self-management is still not widely accepted by patients mainly due to lack of confidence. Most respondents stated that the main barriers could be overcome with adequate clinic time to address patient concerns and encourage them to try managing their pessary themselves.

DISCUSSION

This study focused on understanding the organisational setup of urogynaecology clinics and evaluating the obstacles, as viewed by the BSUG specialists, in implementing pessary self-management for patients with pelvic organ prolapse. This study demonstrated that a significant number of patients who are suitable for pessary self-management are currently receiving clinic-based care in the UK. Those units with the availability of regular nurse-led clinics and higher number of urogynaecology specialist nurses tend to offer pessary self-management tuition to more of their patients compared to other units. One of the top three challenges faced by healthcare professionals in implementing a pessary self-management service is the lack of human resources. This highlights the importance of recruiting and training more urogynaecology specialist nurses in the UK and of having a recognised clinical training and academic pathway for urogynaecology nurses. Vaginal pessary service is delivered by various healthcare professionals worldwide. In Australia it is commonly delivered by appropriately trained physiotherapists,⁷ whilst in the UK, physiotherapists rarely offer pessary services. The role of the urogynaecology nurse is developing into an essential resource in every gynaecology

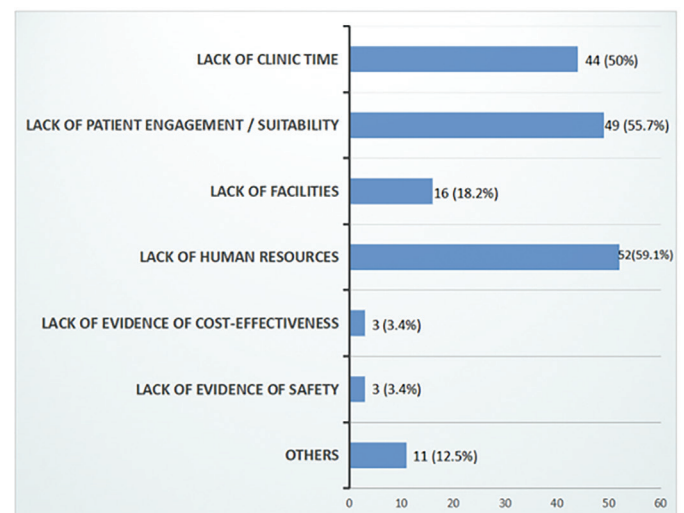


Figure 2. The challenges in expanding pessary self-management tuition

unit, similar to colposcopy nurses and hysteroscopy nurses, but various units are at different stages of embracing this role, partly due to the lack of a recognised training programme. Dwyer et al.⁸ highlighted the importance of having a robust training or guidance for pessary practitioners offering pessary services to women.

The UK Clinical Guideline for best practice in the use of vaginal pessaries for POP recommends that women who are identified to be suitable for pessary self-management should be offered the option to manage their own pessaries.⁹ There are several studies confirm the feasibility of women managing their own pessary,^{10,11} and they suggest that it is associated with fewer complications compared to clinic-based care.¹² Attending the clinic every 6 months to change the pessary can have an impact economically on the healthcare system and personally to the patient. It also has a carbon footprint related to travel. The TOPSY trial demonstrated the cost-effectiveness of pessary self-management compared to clinic-based care.¹³ According to the responses received in this survey, more than half of the units were seeing at least three patients who are suitable for pessary self-management per week, but only 44% of the respondents' units offered pessary self-management tuition to more than half of their suitable patients. This implies that a significant number of patients who are suitable for pessary self-management are currently receiving clinician-led care. This has also been reported by Paulussen et al.¹⁴ who found that 80% of the patients who were receiving clinic-based care were suitable for self-management. The 2024 Royal College of Obstetricians and Gynaecologists report demonstrated that waiting lists for gynaecology in the UK have increased by a third since 2022.¹⁵ If those units start to expand the service of pessary self-management, it may enable them to manage their clinic waiting times better.

A number of specialists felt that many patients would not be suitable for or keen to self-manage their pessaries. This view is also borne out of a survey of women in the UK. Dwyer et al.'s¹⁶ survey of 89 women showed that 50% of women who were not taught pessary self-management before, were not willing to learn to self-manage their pessary. The reasons provided were lack of confidence; feeling physically unable; wanting clinician-led care and fear of problems or previous problems with their pessary. However, the TOPSY trial showed that pessary self-management is suitable for and well mastered by most women.⁵ One explanation for the above views by patients and carers is unchallenged traditional views of paternalistic care. These can be overcome by education.⁸ Concerns of women and carers can be addressed by training and education to affect a culture change in which self-management of pessary is a routine default option. A study by Mohamed and Eltohamy¹⁷ mentioned that nurses

should educate women regarding self-care of vaginal pessaries as this would increase their confidence. They concluded that empowering self-management of pessary in women with POP tends to improve the quality of life of women using vaginal pessaries. Another explanation for these views amongst carers is the resistance to let go of a recurring, relatively easy and in the case of private care, profitable-consultation. To address this, health policies and health insurance remuneration plans need to change to encourage and promote self-management of medical conditions.

One of the strengths of this study is that, to our knowledge, it is the first national study of factors influencing the offer of pessary self-management tuition for patients from the specialist viewpoint. Understanding the views of those healthcare professionals will greatly improve the success rate in expanding pessary self-management service because they are the care providers for women with POP and they know the dynamics within their department. The survey was conducted using a reliable method, collecting a mixture of quantitative and qualitative data.

Study Limitations

One of the limitations of this study is the relatively low response rate, with only 88 responses received from the 466 BSUG members contacted. This relatively low response rate introduces the potential for non-response bias, where the views and experiences of those who chose to participate may differ systematically from those who did not respond. For example, respondents may have been more engaged with the topic or more likely to work in units already offering pessary self-management, potentially leading to an overestimation of awareness, acceptance, or implementation of the practice. Consequently, the findings may not be fully representative of the wider clinical landscape in the UK. Despite the low response rate, the findings obtained reflect a diverse range of clinical settings and professional perspectives, offering valuable insights into current practice. Future research with improved response rates or supplementary qualitative methods could help to validate and build upon these findings. Another limitation of this survey is the lack of in-depth information about obstacles in implementing pessary self-management in individual units. Even though there were free text columns provided to encourage respondents to leave their comments and elaborate further on their views, there were only 40 free text comments received out of the 88 responses. Free text comments may not provide an in-depth insight into the reasons behind the reduced rate of offering pessary self-management tuition compared to qualitative interviews. It is possible that some respondents were from the same units leading to duplication. Also, the survey was exclusive

to specialists. Patients, nurses, and health managers could have different views on the issue. Therefore, further qualitative research may be conducted to investigate the perspectives of patients, healthcare professionals, and healthcare managers concerning pessary self-management.

CONCLUSION

Further in-depth qualitative research with a focus on implementation will provide more information on the challenges faced in expanding a the pessary self-management service. This, in turn, may facilitate the identification of effective strategies to address these challenges and enhance the uptake of pessary self-management across the UK.

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FOOTNOTES

Contributions

Concept: A.K., Design: C.Y.Y., M.D., R.K., S.H., C.B., A.K., Analysis or Interpretation: C.Y.Y., A.K., Writing: C.Y.Y., M.D., R.K., S.H., C.B., A.K.

DISCLOSURES

Conflict of Interest: No conflict of interest was declared by the authors.

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