Case report

The use of triple vaginal ring pessaries in procidentia prior to total Prolift™ procedure

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Abstract: A grandmultiparous (G7P5) 78 year old woman presented with total procidentia with total eversion of the vagina which was oedematous and ulcerated. She complained of dribbling of urine, urgency and urge incontinence. She was very keen on surgical repair. Vaginal packing, single and double vaginal ring pessaries had failed to reduce the procidentia preoperatively. She was fitted with three ring pessaries: size 59 mm was inserted first, then 77mm followed by 95mm. This resulted in reducing her genital prolapse which allowed the vaginal ulcers to heal before a definitive surgery by vaginal hysterectomy, and total prolift procedure was undertaken about one month later. The procedure and recovery were uncomplicated and when reviewed 7 weeks postoperatively, she was asymptomatic with excellent vaginal support.

Key words: Procidentia, Prolift; Vaginal Ring Pessary.*

INTRODUCTION

Long-standing procidentia results in venous congestion, oedema, decubitus ulcers and infection. Preoperatively, the procidentia needs to be reduced for a sufficient period of time to allow healing of these ulcers. This management decreases intra-operative bleeding and complications. It may be impossible to reduce the prolapse in some of these women if the vagina cannot retain single or double pessaries. I have used triple pessaries in the management of the case presented.

CASE REPORT

A grandmultiparous (G7P5) 78 year old woman presented to the emergency department with a very uncomfortable mass protruding out of the vagina that had been progressively increasing in size. Initially, the mass had been reducible but it had been irreducible for over a year. Concomitantly, she complained of dribbling of urine, urgency and urge incontinence. She suffered from hypertension, gout and osteoarthritis which were very well controlled by medications. On general examination she was well for her age and abdominal examination revealed no abnormality. Pelvic examination revealed a total procidentia with total eversion of the vagina which was oedematous with marked ulceration. In spite of her age and not being sexually active, she was very keen on definitive surgical repair. Different surgical options were discussed with her and she was keen on hysterectomy and total prolift procedure. She was informed that the vaginal ulcers and oedema needed to be treated before any attempt of surgical treatment. Single and double vaginal ring pessaries, as well as vaginal packing following hospital admission, all had failed to stay in to reduce the procidentia in order for the vaginal ulcers to heal prior to any surgical procedure.

A further attempt was then made, after manual reduction of the prolapse, by fitting three ring pessaries: size 59 mm was inserted first, then 77 mm followed by 95 mm (Fig. 1). The process of insertion of the three pessaries was very well tolerated by the patient and, after their insertion, she felt very comfortable and relief of her urinary symptoms with no further urine dribbling. Before she was sent home, another lengthy discussion took place about different surgical options with their pros and cons. Patient was given a date for review in 2 weeks in the outpatient clinic and also a date in about a month's time was listed for surgical correction of her prolapse by vaginal hysterectomy and total prolift. She was also advised to use oestrogen therapy in the vagina every night.

The patient attended the outpatient clinic a few days later when the rings were expelled on that morning as she strained to open her bowels. She stated that she was comfortable when the rings were in the vagina with continuous relief of the urinary symptoms that troubled her before the insertion of the triple pessaries. There was much improvement of thee vaginal ulcers and oedema since the insertion of the pessaries 3 days ago. The patient was fitted again with the same size pessaries and was advised to avoid constipation and excessive straining when opening her bowels. She was further advised to digitally support the pessaries during defaecation and to keep her appointment for review in the pre-operative clinic.

About two weeks later, she was reviewed in the preoperative clinic. The pessaries were still in place and vaginal ulcers and oedema were markedly improved (Fig. 2). The patient was offered to continue with conservative management with the triple pessaries, but she declined and was keen to go ahead with the surgery as planned.

About one month from the patient's initial presentation, she underwent vaginal hysterectomy and total prolift procedure. The vaginal ulcers were completely healed. The procedure was straightforward with minimum blood loss and the postoperative recovery was excellent. As planned, the vaginal pack that was inserted at the end of her procedure was removed on the 2nd post-operative day and the Foley's urinary catheter that was inserted at the beginning of the surgery was removed on the 4th postoperative day. As the post-void residual urine was less than 100 ml, she was then sent home on the 4th post-operative day.

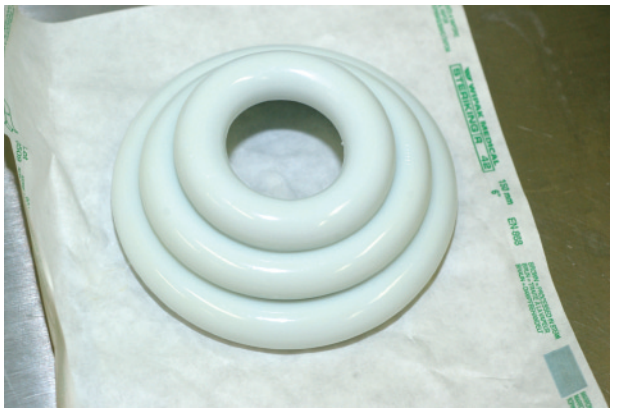

Fig. 1. – The triple ring pessaries with the smaller one to be inserted first.

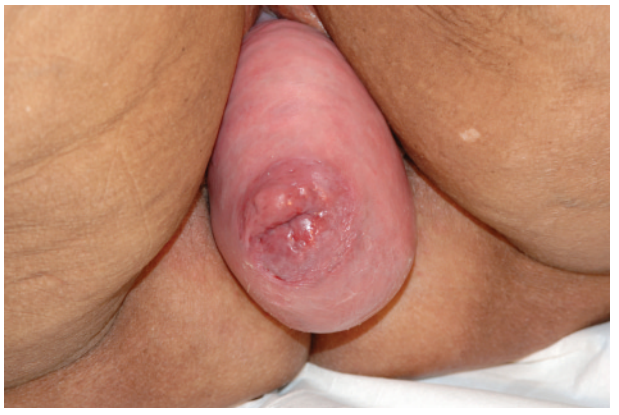

Fig. 2. – Total Procidentia, there was marked improvement of the vaginal ulcers and oedema after conservative management with the triple pessaries.

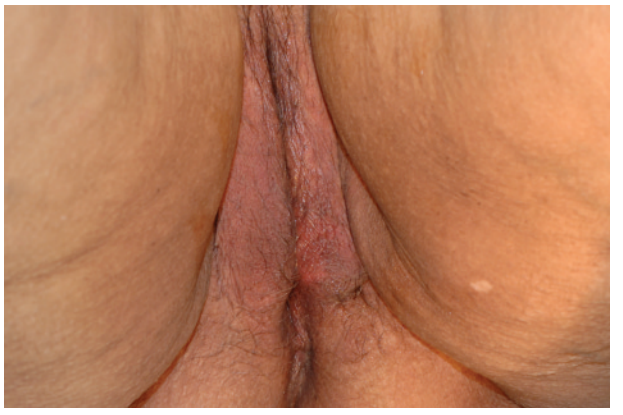

Fig. 3. – The patient 7 weeks following vaginal hysterectomy and total prolift procedure.

The patient was reviewed in the outpatient clinic 7 weeks postoperatively; she was asymptomatic and very pleased with the outcome of her surgery. On examination there was excellent vaginal support (Fig. 3). She was discharged from the clinic.

DISCUSSION

A survey of the pattern of gynaecologists and urogynaecologists of prescribing pessaries in the United States indicated that the ring pessary is used most often and is deemed the easiest to use.[1, 2] In a large retrospective study, 71% of patients were found suitable to be initially fitted with a pessary, but three weeks later the overall success rate was only 41%.[3]

Treatment of massive pelvic organ prolapse in elderly women is a very challenging clinical problem. Conservative management by pessaries is usually offered to women considered unfit for surgery but it is not always successful. Singh and Reid reported insertion of double vaginal ring pessaries in 18 patients, in 3 of them the rings were expelled immediately.[4] In correspondence to this publication it was suggested that for these three women a third ring pessary might have been tried.[5] In five patients with grade 4 pelvic organ prolapse in whom single pessary was unsuccessful, double pessaries (either Donut or Inflatable, followed by flexible Gelhorn or Shaatz) were successful in their management.[6] Varma & Kunde described a two-stage approach in four women with massive prolapse, two of these women tried and failed with double ring pessaries. Initially colpoperineoraphy was performed with insertion of a ring pessary followed by definitive surgery 6 weeks later.[7] It may be argued that LeFort colpocleisis is a shorter procedure and potentially has less intraoperative morbidity compared to total prolift procedure. However this procedure may result in specific long-term problems that may not appeal to some patients in spite of their age.[8] In this patient there were no intraoperative or postoperative complications with the total prolift procedure and the outcome was excellent.

CONCLUSION

A trial of insertion of triple vaginal ring pessaries is worthwhile in women with massive pelvic organ prolapse when some other measures have been tried without success. Total prolift procedure is a feasible option for surgically fit elderly patients with massive prolapse.

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