



Royal College of
Obstetricians &
Gynaecologists

Joint RCOG/BSUG Guidance on Management of Urogynaecological Conditions and Vaginal Pessary Use During the COVID-19 Pandemic

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1. Introduction

This guidance has been developed by the British Society of Urogynaecology (BSUG) to provide ongoing support to urogynaecology services during the COVID-19 pandemic. With the added impact of new variants of COVID-19, service delivery remains challenging and it is important to be prepared. Within gynaecology, urogynaecology services have seen the maximum disruption owing to the fact that many of these patients have chronic conditions and often these women are more vulnerable because of their age and the increased likelihood of age-related comorbidities.

This guidance outlines which elements of care need to be prioritised and the modifications required to deliver urogynaecology services in light of the national recommendations for social distancing to ensure safe and sustainable service delivery during the ongoing pandemic. This guidance should be used in conjunction with prevailing government and National Institute of Health and Care Excellence (NICE) guidance and regulations.

This guidance has been produced rapidly to meet an urgent need in light of the current medical emergency, therefore the usual level of peer review scrutiny has not been undertaken. This document does not form a directive but should be used by individual healthcare professionals to inform their practice.

The objectives are:

1. To reduce the risk of person-to-person transmission of COVID-19.
2. To optimise care in urogynaecology services.
3. To best utilise human (medical and nursing) and physical resources in this time of national medical emergency.

2. General guidance

When women are asked to come for an in-person review, it should be ensured that they are not symptomatic of COVID-19 or in an extremely vulnerable group. If this is the case, their review should be deferred where possible and until safe to do so.

2.1 Outpatient consultations

Most women seen in urogynaecology clinics attend with non-urgent conditions such as prolapse and/or incontinence. There are very few situations where they would present as an acute medical emergency or where an emergency admission to hospital is required. It is also important to note that a large proportion of these women are over 60 years of age making them more vulnerable should they contract COVID-19 as they are more likely to require hospitalisation. No clear guidelines exist on the use of virtual consultations in urogynaecology services,¹ but evidence accumulated since the start of the pandemic suggests that virtual consultations is useful for follow-up, postoperative assessment and for women with lower urinary tract symptoms, but less so for women with a pelvic organ prolapse as

they need to be physically examined.^{2,3} Therefore, the BSUG recommends a pragmatic approach to the care of patients attending urogynaecology clinics. Although urogynaecological conditions are generally non-urgent, one should be aware that some women with prolapse have been waiting for surgical treatment since the beginning of the pandemic, and the degree and severity of prolapse may have worsened in some of these cases. Hence, there should be adequate local processes in place to identify these women and expedite their review and treatment if necessary.

2.2 Vaginal pessary care

Women with vaginal pessaries are a particular group who require regular follow-up, often performed in the secondary care environment. It is recommended that telephone consultations take place in the first instance, where most women can be reassured that a slight delay of a few months to the pessary change will have no harmful effects. This consultation can also be used to identify those women who can have a delayed review (over 3 months), those that require review within 30 days and those who need to be seen semi-urgently (within 7 days).

2.3 Urodynamics and outpatient urogynaecology treatment clinics

With increasing waiting lists for urodynamic services, some units have now resumed this activity. Similarly, outpatient treatment clinics for procedures such as percutaneous tibial nerve stimulation, bladder instillations, intravesical botox injections, urethral bulking agents and diagnostic cystoscopy (non-cancer indications) have also resumed. Cases should be prioritised in view of need and a woman's wishes. Women will be required to wear a face mask and staff should wear both a mask and a visor. Stringent infection control measures should be in place and there may be a need to reduce the number of patients on a clinic list to allow for down time between patients.

2.4 Elective surgery

Elective surgical services had resumed over the past few months although there has been a recent suspension again with rising cases; it is important to follow local or NICE⁴ guidance when scheduling surgery with regards to self-isolation preoperatively and swabbing policy. Women should be informed of the added risks of COVID-19 pneumonia if they choose to undergo surgery during the pandemic in spite of all precautions. The BSUG have developed patient information leaflets (Appendix I), checklists for surgery (Appendix II) and COVID-19 specific consent forms (Appendix III).

When scheduling surgery, units should be particularly cognisant of evidence that individuals from a black, Asian or minority ethnic (BAME) background are at particular risk of developing severe and life-threatening COVID-19. Particular consideration should be given to the experience of women of BAME background and/or of lower socioeconomic status, when evaluating the need to proceed to surgery during the pandemic.

In women undergoing laparoscopic urogynaecology surgery the RCOG/British Society for Gynaecological Endoscopy (BSGE) advice on [Gynaecological endoscopy during the COVID-19 pandemic](#) should be followed.⁵

Adequate personal protective equipment should be worn based on the infection risks of individuals and the anaesthetic being used.

3. Pathways for common conditions

3.1 Emergency/urgent review (within 12 hours)

3.1.1 Urinary retention

Women presenting with urinary retention (postnatally or otherwise) if newly diagnosed need an urgent review to prevent bladder injury. It may be possible to see these women within a gynaecology/postnatal ward where nurses/midwives are trained to catheterise patients and monitor residual urine. The initial management will usually be with an indwelling catheter with a review in 1 week for a Trial Without Catheter (TWOC).

Procidentia (sudden onset or gradual worsening) with severe oedema, engorgement with or without ulceration, and pain associated with urinary retention or bowel evacuation problems, needs urgent review.

3.2 Semi-urgent review (within 7 days)

3.2.1 Trial Without Catheter (TWOC)

Women requiring a TWOC need to be seen to ensure their post void residuals are within normal ranges (follow hospital guidelines). If post void residuals are raised, women should be taught self-catheterisation where appropriate to avoid repeat admissions to hospital. It may be possible to defer TWOC for a few weeks, but this needs to be reviewed on a case-by-case basis, especially for those women who may have been in contact with a suspected or confirmed case of COVID-19, or have symptoms themselves.

3.2.2 Fistulation from a pessary

Severe problems arising from a pessary left in situ are relatively rare. When they occur, it is usually in relation to Gellhorn and shelf pessaries. In this instance a review within 7 days may be required for removal of the pessary.

3.3 Early review (within 30 days)

3.3.1 Pessary review for problems

Where it is identified that a pessary is causing problems such as bleeding, pain or ulceration, women should be asked to attend an in-person consultation provided they fulfil the aforementioned criteria (they are not symptomatic for COVID-19 or in an extremely vulnerable group). Post-menopausal

bleeding (PMB) in women with an intact uterus and a vaginal pessary for prolapse should be referred via the local PMB cancer pathway.

3.3.2 Procidentia with or without bladder and bowel problems

Women with procidentia without severe oedema and engorgement may need to be reviewed within 30 days. If, however, this is a long standing condition and it causes minimal inconvenience then review may be delayed.

3.4 Up to 3 months

3.4.1 Suprapubic catheter changes

Change of suprapubic catheters can be delayed for up to 3 months. Where feasible, a district nurse may be asked to visit the woman and perform the change in their home to avoid a visit to hospital.

3.5 After 3 months

3.5.1 Pessary review (routine)

All routine ring pessary changes may be delayed for 3 months in the first instance and up to a maximum of 6 months from when the last change was due. For Shaatz, Gellhorn, shelf or double pessaries review/delay should not be beyond the 3 months from when the change was due. When left in situ for longer than 6 months the risk of ulceration and incarceration increases.⁶⁻⁸ This usually presents with symptoms such as discharge and bleeding.⁹ Women should be given a contact number should they develop problems while they are waiting for a review or a change of their pessary.

Empiric estrogen use should be considered and discussed with the woman to reduce the risk of vaginal erosions owing to the increased gap between changes, and for those women who are capable of removing and reinserting pessaries, they should be encouraged to do so.

Women with pessary problems who are COVID-19 positive can be advised to remove their pessary where feasible, until they are able to attend for clinical review. For those women where the prolapse is too advanced to allow safe removal or those who are unable to remove their own pessary, in-person review will need to take place after the period of self-isolation.

3.5.2 Routine referrals for prolapse and lower urinary tract symptoms, rescheduled and cancelled patients for surgery

All women should be given the option of a telephone/video consultation as many will be anxious about attending. Even new patients appreciate the opportunity to establish a relationship with a clinician via a telephone consultation,¹⁰ although they may eventually require physical examination. Completion of Patient Reported Outcome Measures prior to attendance allows an assessment of the most bothersome symptoms and better discussion about patient expectations.¹¹

Where surgery has been cancelled owing to the pandemic, telephone consultations allow an opportunity to discuss alternative therapies as well as establishing when surgery may proceed. Many women are choosing to defer surgery until after the pandemic is resolved, especially if this is a problem they have lived with for many years already.

3.5.3 Bladder retraining and pelvic floor muscle training

Bladder retraining can be undertaken remotely by requesting the woman to keep a bladder diary with instructions in advance of the consultation. Women's health pelvic floor physiotherapy has been hugely affected during the COVID-19 pandemic. Virtual physiotherapy is an emerging concept and women with lower urinary tract symptoms can continue to receive care through this medium. This promotes continuity of care and allows women to complete sessions of conservative treatment during the pandemic.

Appendix I: COVID-19 information for women preoperatively

You have been scheduled for an operation and you have agreed to come in for surgery.

COVID-19 is likely to be with us for some time and so there are number of specific points that you need to be aware of. They are not meant to scare or upset you or put you off surgery but to make sure you are fully informed before you are admitted to hospital. Hopefully these will have already been discussed with you by your surgeon.

You need to understand that:

- While the hospital strives to provide surgery in the safest manner possible with patients and staff being monitored and tested for COVID-19 infection, it cannot be guaranteed that the hospital is coronavirus-free. There may also be emergency patients admitted who have not been able to self-isolate.
- Despite all precautions and social distancing measures, coming into hospital – even if for just a day case procedure – might increase your risk of catching COVID-19.
- Catching COVID-19 while in hospital can make you seriously ill, delay your recovery and can carry significant risks to you and your health.
- Your operation might not be done by the doctors you have been seeing so far, but your surgeon will be suitably trained to perform your surgery.
- If you require critical care (ITU or HDU) you might end up having to be transferred to another hospital.
- You might not be allowed any visitors during your hospital stay.
- You will have to self-isolate for up to 14 days (depending on the hospital policy)¹² before your procedure.
- It is advisable to maintain 'shielding' while you are recovering from your surgery as during this recovery period you may be more at risk from the effects of COVID-19.
- You will need a preoperative coronavirus test before your procedure. Attending for this and pre-assessment then returning straight home is allowed during self-isolation. If your test comes back positive your surgery will be deferred until you have recovered and receive a negative test.
- You will be asked to sign a consent form to confirm that you understand all of this when you come in for surgery.

Appendix II: COVID-19 checklist for consultations prior to listing for surgery

The information given to patients in consultations either in-person or by telephone should include specific points with regard to the risks of COVID-19. Anyone who comes into hospital for a procedure during the pandemic will inevitably be increasing their risk of contracting COVID-19, and they should be asked to sign a consent form to highlight that they have been warned of these risks. As we know that consent is a process, not a piece of paper, it follows that the information-giving process must begin in the clinic setting.

As there is no strong evidence of immunity following exposure, this guidance applies to all, including those with a previous diagnosis of COVID-19.

So, for any woman considering an elective procedure, the following should be discussed and recorded in the notes (either paper or electronic).

- The pros and cons of the specific procedure under consideration and the alternatives to treatment which may not involve attending the hospital site.
- The risks of intervention **now** (coronavirus risks) versus the risks of **delaying** treatment.
- While the hospital will strive to provide surgery in the safest manner possible, as it accepts emergency patients it cannot be guaranteed that the whole hospital is coronavirus-free and thus, despite all social distancing measures, coming to hospital might increase the risk of catching COVID-19.
- If they catch COVID-19 while in hospital it may significantly delay their recovery, and increase their risk of being seriously ill and even of death.
- The operation might not be conducted by the doctors they have been seeing so far, but that the surgeon will be suitably trained to perform their surgery.
- If there is a need for critical care they may end up being moved to another hospital.
- They are unlikely to be allowed visitors.
- If the woman chooses to delay intervention then she must have the specific disease-related risks of delay described and wherever possible quantified. She must be told that rearranging future dates for surgery will probably take much longer than normal.
- The woman will be expected to undertake a period of self-isolation prior to surgery up to 14 days¹² and depending on hospital policy and have at least one negative coronavirus swab.
- In the event of the woman testing positive for coronavirus, the surgery will be deferred which may have an impact on the outcome of the underlying disease/condition.

- It may be advisable to maintain 'shielding' while recovering from surgery as being postoperative may leave the woman more at risk of the effects of COVID-19.

Appendix III: COVID-19 specific consent form

Name:
Address:
Hospital Number:
DoB:

General:

- The alternatives to the procedure I am attending for have been discussed with me, as have the risks of not proceeding with the procedure which could include a worse outcome from the underlying disease.
- I have been warned that attending hospital might increase my risk of catching COVID-19.
- I have been warned that if I do catch COVID-19, it may make my recovery from my procedure more difficult, it may increase my risk of serious illness or even death.
- I have been warned that if I need critical care during my stay I might be moved to another hospital.
- It has been explained that it is likely that I will not be able to have friends and family visit me while in hospital.

Specific:

- I have not experienced any COVID-19 symptoms during the self-isolation period.
- I confirm that I have been self-isolating for the number of days requested by my hospital.
- No members of my household or other contacts have been unwell with COVID-19 symptoms during the self-isolation period.¹²
- I have undergone COVID-19 swab testing and understand that I have tested negative for COVID-19.

Patient

Signature:

Name (PRINT):

Date:.....

Clinician

Signature:

Name (PRINT):

Date:

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