Cochrane for Clinicians

Putting Evidence into Practice

Pessaries for Managing Pelvic Organ Prolapse in Women

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Clinical Question

Are pessaries effective in treating pelvic organ prolapse in women?

Evidence-Based Answer

Pessaries combined with pelvic floor muscle training (PFMT) probably improve pelvic organ prolapse symptoms in women (number needed to treat [NNT] = 3; 95% CI, 2 to 6) and prolapse-specific quality of life compared with PFMT alone. However, the risk of adverse events (abnormal vaginal bleeding) may be higher (number needed to harm [NNH] = 27; 95% CI, 5 to 111).[1] (Strength of Recommendation: B, based on inconsistent or limited-quality patient-oriented evidence.)

Practice Pointers

Pelvic organ prolapse is characterized by pelvic organs such as the uterus, bladder, or bowel protruding into the vagina because of pelvic floor muscle weakness. Common symptoms include a feeling of "something coming down," vaginal or pelvic pain, urinary and/or bowel symptoms, and sexual difficulties, and these can significantly worsen patient quality of life.[2] About 40% of women older than 40 years are affected,[3] and the prevalence is expected to increase as the population ages. Treatment options include pessaries, PFMT, and surgery. Clinicians commonly offer pessaries as first-line treatment. The authors of this review aimed to determine the effect of pessaries in the management of pelvic organ prolapse.

These are summaries of reviews from the Cochrane Library.

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This Cochrane review included four randomized controlled trials involving 478 women with a mean age of 30.4 to 65.6 years at various stages of prolapse and follow-up ranging from six weeks to two years.[1] One trial compared the use of a pessary with no intervention, the second compared a pessary and PFMT, the third compared pessary and surgery, and the fourth trial compared pessary plus PFMT with PFMT alone. Improvement of prolapse symptoms was measured using the validated Pelvic Floor Disability Index or the Pelvic Organ Prolapse Symptom Score. Prolapse-specific quality of life was measured using the Pelvic Floor Impact Questionnaire (PFIQ), with lower scores representing improved quality of life (on a scale of 0 to 100). Meta-analysis could not be performed because each trial addressed a different comparison.

Three trials reported data on perceived improvement of prolapse symptoms. At 12 months, compared with PFMT alone, pessary plus PFMT may improve symptoms (absolute risk reduction = 32.4%; 95% CI, 16.3% to 54.6%; NNT = 3; 95% CI, 2 to 6; n = 260; moderate-certainty evidence). Two trials reported data on prolapse-specific quality of life. At 12 months, pessary plus PFMT probably improves prolapse-specific quality of life compared with PFMT alone (median PFIQ interquartile range score was 0.3 in the pessary plus PFMT group vs. 8.9 in the PFMT-only group; P = .02; moderate-certainty evidence). Pessary plus PFMT may slightly increase the risk of abnormal vaginal bleeding (NNH = 27; 95% CI, 5 to 111; n = 260; low-certainty evidence). It is uncertain if pessaries improve pelvic organ prolapse symptoms compared with no treatment or PFMT alone.

The above conclusions should be interpreted with caution because of small sample size. However, they are consistent with guidance from the National Institute for Health and Care Excellence, which supports use of a pessary alone or in conjunction with supervised PFMT for women with symptomatic pelvic organ prolapse.[4] The American College of Obstetricians and Gynecologists recommends that symptomatic women be offered a pessary as an alternative to surgery, and that a pessary be considered as part of preconception care for symptomatic women who wish

to become pregnant in the future.[5] Future high-quality trials should also measure other clinically relevant outcomes, such as perceived resolution of prolapse symptoms, patient-reported satisfaction, or psychological impact.

The practice recommendations in this activity are available at http://www.cochrane.org/CD004010.

Editor's Note: The absolute risk reduction, numbers needed to harm and to treat, and confidence intervals reported in this Cochrane for Clinicians were calculated by the authors based on raw data provided in the original Cochrane review.

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Psychological Therapies for Women Who Experience Intimate Partner Violence

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Clinical Question

Are psychological therapies safe and effective for women who experience intimate partner violence (IPV)?

Evidence-Based Answer

Psychological therapies decrease depressive symptoms (standardized mean difference [SMD] = 0.24; 95% CI, 0.01 to 0.47) and anxiety symptoms (SMD = 0.96; 95% CI, 0.63 to 1.29). It is unclear if they improve self-efficacy (i.e., a belief in one's own ability to cope with challenging life situations), posttraumatic stress disorder symptoms, reexposure to IPV, or safety planning. No harmful effects were identified.[1] (Strength of Recommendation: B, based on inconsistent or limited-quality patient-oriented evidence.)

Practice Pointers

IPV describes physical assault, sexual violence, psychological harm, or stalking by a current or former partner.[2] One in three women reports having been a victim of IPV at some time.[1] There is a higher incidence of depression, anxiety and phobias, posttraumatic stress disorder, and alcohol use disorder in women who have been abused by their partners.[3]

The authors of this analysis sought to determine whether psychological therapies benefit women who have experienced IPV.[1] They included 33 randomized controlled trials (RCTs) and quasi-RCTs, with a total of 5,517 women 16 years and older; the average age of participants was 37 years. Most trials were conducted in high-income countries, including the United States (58%). The participants were recruited from health care, community, shelter, or refugee settings and had a wide range of education levels, relationship statuses, and ethnic backgrounds. An exception was socioeconomic status; 66% of participants were unemployed.

The psychological therapies in the study groups were mostly delivered face-to-face by staff with varied levels of training. The length of treatment ranged from two to 50 sessions. Control groups received usual care, which involved no treatment or delayed or minimal intervention. Depression was quantified using the Beck Depression Inventory, Center for Epidemiologic Studies Short Depression Scale, and Patient Health Questionnaire. The authors also attempted to determine whether there was significant harm, as determined by participant dropouts at six to 12 months of follow-up. Secondary outcomes were symptoms of anxiety, quality of life, reexposure to IPV, safety planning and behaviors, use of health care and IPV services, and social support. Scales for anxiety included the Beck Anxiety Inventory; the State-Trait Anxiety Inventory; and the Depression, Anxiety, and Stress Scale. The primary outcomes were depression and self-efficacy.

Depressive symptoms were improved in those treated with psychological therapies compared with those in the control groups over six to 12 months (SMD = 0.24; 95% CI, 0.01 to 0.47; n = 600). The trials showed consistent results and had low risk of bias. Two other studies

(n = 528) demonstrated that psychological therapies improve depressive symptoms at six to 12 months compared with the control groups.

The reported data showed no evidence that psychological therapies have an impact on self-efficacy. There were no noted differences in dropouts. Anxiety symptoms were also improved in those treated with psychological therapies delivered for up to six months compared with the control groups (SMD = 0.96; 95% CI, 0.63 to 1.29; n = 158).

No harmful effects were demonstrated in the intervention groups. This review was limited by the various types of interventions and the various study durations. Given these limits, there is reason to believe that further studies might alter the conclusions.

Current U.S. Preventive Services Task Force guidelines recommend that clinicians screen for IPV in women of reproductive age and, for those who screen positive, provide them with or refer them to ongoing support services.[4]

The practice recommendations in this activity are available at http://www.cochrane.org/CD013017.

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