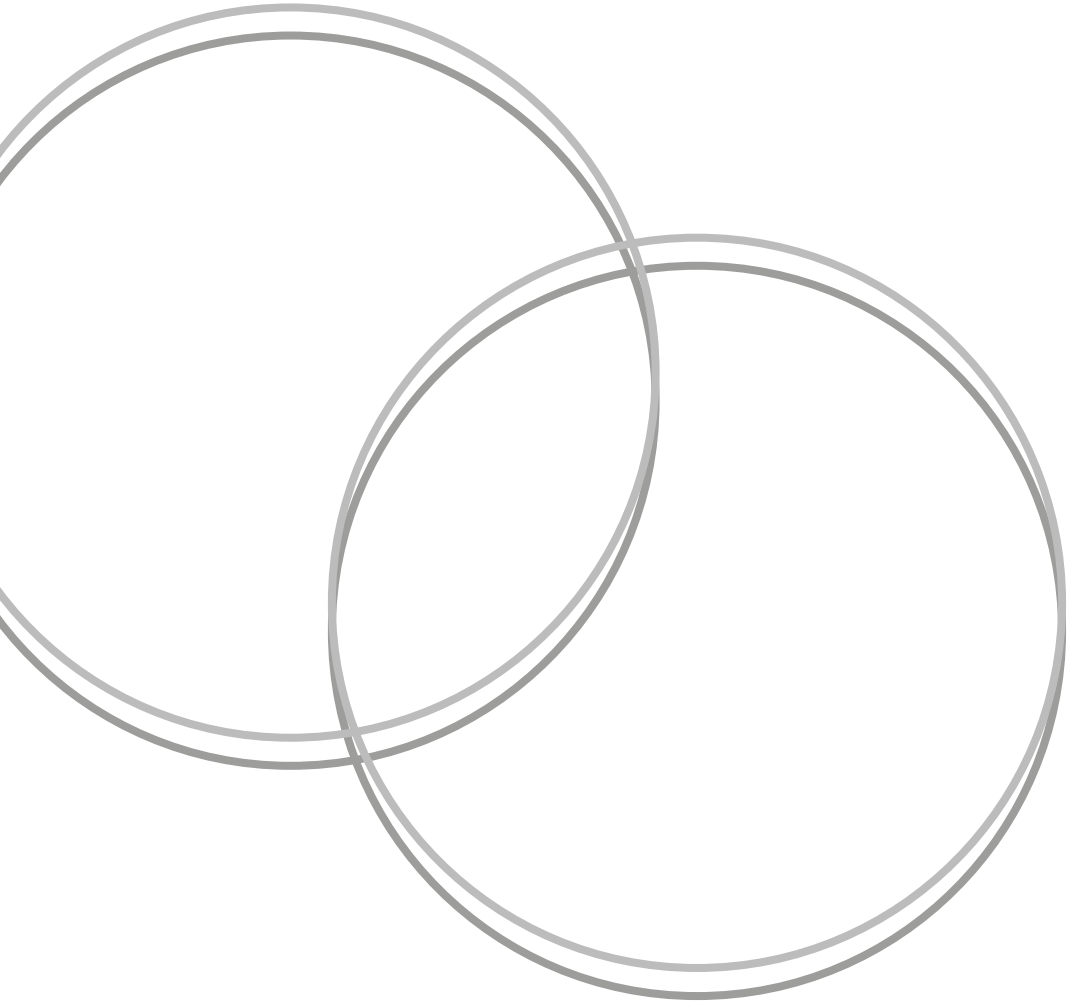
NHS
Oxford University Hospitals
NHS Foundation Trust

The Arabin Pessary

Information leaflet



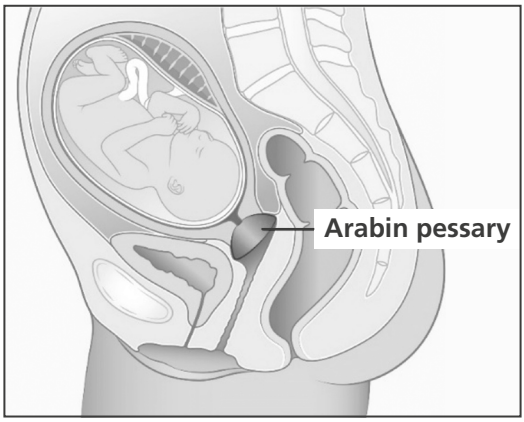
Gender inclusive language in OUH Maternity and Perinatal Services:

- This leaflet uses the terms woman, women and mother throughout. These terms should be taken to include people who do not identify as women but who are pregnant. Similarly, where the term parent(s) is used, this should be taken to include anyone who has main responsibility for caring for a baby.
- The term partner refers to the woman's chosen supporter. This could be the baby's father, the woman's partner, a family member or friend, or anyone who the woman feels supported by and wishes to involve in their care.

What is an Arabin pessary and how does it work?

An Arabin pessary is a soft silicon ring that is inserted into the vagina. It is positioned at the top of the vagina and moved into place so that the cervix sits inside the hole in the centre of the pessary. The cervix then swells up and holds the pessary in place.

The pessary is thought to work by supporting the cervix and preventing it from shortening and dilating (opening).



What is it used for?

The Arabin pessary may be recommended as an alternative to a cervical stitch (cerclage) for women who have an increased chance of late miscarriage or preterm labour and birth.

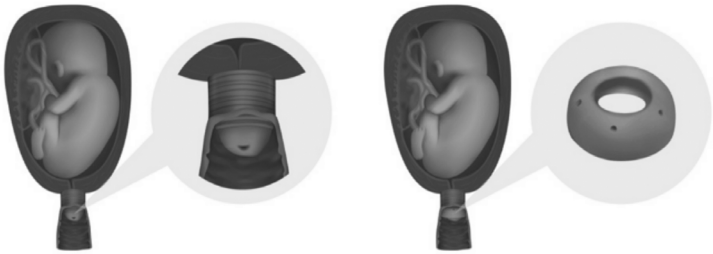
When is it inserted?

The pessary should only be inserted on the recommendation of a preterm labour specialist midwife or fetal medicine consultant, after discussion with you.

It can be inserted anytime between 12 and 26 weeks of pregnancy, by a preterm labour consultant, or the preterm labour specialist midwife.

What are the advantages of the Arabin pessary?

- It is quick and easy to insert.
- No anaesthetic or pain relief is required for insertion or removal and most people will not be able to feel the pessary once it is inserted correctly.
- It can be inserted and removed in a clinic room.
- It is still safe to have speculum examinations, vaginal swabs for infection (if needed) and internal (transvaginal) scans with the pessary in-situ (in place).
- Fetal fibronectin testing (a test to assess the chance of preterm labour) can still be performed with the pessary in-situ.
- It can be considered for use in women carrying a multiple pregnancy (such as twins).



What are the disadvantages of the Arabin pessary?

- The pessary can cause increased vaginal discharge which may be quite heavy and/or watery. An increased amount of vaginal discharge is not necessarily a sign of infection but can be confused with ruptured membranes (waters breaking). If there are any concerns, you should seek medical advice from the Maternity Assessment Unit (MAU). The contact details for MAU are on page 7 of this leaflet

- Subsequent transvaginal scans to assess the cervix may be more challenging with an Arabin pessary in situ.
- There can be discomfort if the pessary is not sitting in the right place. If you experience discomfort, you should seek medical advice from the MAU. An appropriately trained healthcare professional will check the position of the pessary either digitally (using gloved fingers) or by transvaginal ultrasound scan. Advice will be sought from the preterm team if there are any concerns.
- Sexual intercourse is not advised with the pessary in place.
- Evidence suggests the pessary may be less effective than cervical cerclage at preventing preterm labour. A preterm labour consultant will discuss the options with you. Any decisions will be made in partnership with you using a shared decision-making process.

Routine removal

Arabin pessaries are usually removed in the Antenatal Clinic at 37 weeks of pregnancy.

Premature removal

Premature (early) removal of the pessary should only be performed after discussion with a preterm labour or fetal medicine consultant if:

- There are signs of a systemic (whole body) infection. Local infections (such as Thrush), without maternal or fetal problems, may be treated with the pessary remaining in place.
- There are uterine contractions which do not respond very rapidly to tocolysis and/or the cervix is 4cm dilated or more. Tocolysis is a way of using medications to delay or stop labour from starting, but these are only used in very specific cases.
- There is significant vaginal bleeding, with or without the presence of contractions.

If the waters break without contractions and there are no signs or symptoms of chorioamnionitis (infection), the case should be discussed with a preterm labour/fetal medicine consultant to decide whether to remove the pessary.

If a decision is made for an Arabin pessary to remain in place following confirmed rupture of the membranes, admission to the hospital will be offered.

How is the Arabin pessary removed?

- A doctor will perform a vaginal examination to find the position of the pessary and the cervix; they will then gently push the cervix back through the centre of the pessary.
- The doctor will gently guide the pessary down over the cervix and out of the vagina.
- The pessary will then be disposed of.

Arabin pessary inserted (date and gestation):

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Arabin pessary removed (date and gestation):

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If your waters break or you have any questions or concerns about your pessary you should seek medical advice by contacting:

Contact source	Times available	Contact number
Preterm Team	Monday – Friday 8:00am – 6:00pm	***01865 221716*** ***01865 221393***
Fetal Medicine Unit	Monday – Friday 8:30am – 5:30pm	***01865 221716***
Maternity Assessment Unit	Open 24 hours a day, 7 days a week	***01865 220221***

Further information

If you would like an interpreter, please speak to the department where you are being seen.

Please also tell them if you would like this information in another format, such as:

- Easy Read
- large print
- braille
- audio
- electronic
- another language.

We have tried to make the information in this leaflet meet your needs. If it does not meet your individual needs or situation, please speak to your healthcare team. They are happy to help.

We would like to thank the Oxfordshire Maternity Voices Partnership for their contribution in the development of this leaflet.

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