BNF CHAPTER 7: OBSTETRICS, GYNAECOLOGY, AND URINARY-TRACT DISORDERS

BNF 7.2.1 PREPARATION FOR VAGINAL AND VULVAL CHANGES.

- **Topical HRT for vaginal atrophy**

- **Menopausal atrophic vaginitis,** a cream containing an oestrogen may be applied on a short-term basis to improve the vaginal epithelium. Topical oestrogens should be used in the smallest effective amount to minimise systemic effect

Hormone replacement therapy, see section 6.4.1.1

Local Oestrogens	Product	Component	Typical Dose
Estriol	**Gynest** intravaginal cream	Estriol 0.01%	1 applicatorful daily in the evenings until improvements occur, reduce to one applicator twice a week. Attempts to reduce or discontinue every 3 to 6 months with re-examination.
Estriol	**Ortho-Gynest** pessaries	Estriol 500mcgr	1 pessary daily in the evenings until improvements occur; maintenance 1 pessary twice a week ; attempts to discontinue every 3 to 6 months with re-examination
Estriol	**Ovestin** intravaginal cream	Estriol 0.1%	1 applicatorful daily for 2-3 weeks, reduce to one applicator twice a week. Discontinue every 2-3 months for 4 weeks to assess need for further treatment.

BNF 7.2.2. VAGINAL AND VULVAR INFECTIONS

Please, refer to Chapter 5. Infections Formulary.

BNF 7.3.1 COMBINED HORMONAL CONTRACEPTIVES (COC).

CHOICE:

- ***BNF 61, Mar-11:***
- A preparation with the lowest oestrogen and progestogen content which gives good cycle control and minimal side-effects in the individual woman is chosen.
- *Low strength preparations* are particularly appropriate for women with risk factors for circulatory disease
- *Standard strength preparations* are appropriate for standard use. See Risk of VTE below.
- *Phase preparations* are generally reserved for women who either do not have withdrawal bleeding or who have breakthough bleeding with monophasic products.

    - **Cochrane review (2009),** Biphasic versus monophasic oral contraceptives for contraception Van Vliet HAAM, Grimes DA, lopez LM, Schulz KF, Helmerhorst FM: "Since no clear rationale exists for biphasic pills and since extensive evidence is available for monophasic pills, the latter are preferred […] **One-phase pills are the better choice,** since we have much more evidence for such pills and two-phase pills have no clear reason for use"
    - **Cochrane review (2010),** Triphasic versus monophasic oral contraceptives for contraception Van Vliet HAAM, Grimes DA, lopez LM, Schulz KF, Helmerhorst FM: "The available evidence is insufficient to determine whether triphasic OCs differ from monophasic OCs in effectiveness, bleeding patterns or discontinuation rates […] Some trials

found better bleeding patterns with three-phase pill […] Therefore, we recommend **one-phase pills for women starting to use birth control pills**".

See Management of Unscheduled Bleeding in Women Using Hormonal Contraception (Faculty of Sexual & Reproductive Healthcare) http://www.fsrh.org/pdfs/UnscheduledBleedingMay09.pdf

- ***Faculty of Sexual & Reproductive Healthcare Clinical Guidance.*** UK Medical Eligibility Criteria for Contraceptive Use:
  http://www.fsrh.org/pdfs/UKMEC2009.pdf

- ***CKS (Clinical Knowledge Summaries)***

- In case of Polycystic Ovary Syndrome:
  - If the endometrium is of normal thickness, advise treatment to prevent endometrial hyperplasia. Offer women the choice of either regular withdrawal bleeding at least once every 3 months (using a combined oral contraceptive, COC, or cyclical progestogen) [Balen and Glass, 2005] or the levonorgestrel intrauterine system (IUS) [RCOG, 2007].
  - For women with hirsutism, offer advice about cosmetic measures and consider treatment with a standard combined oral contraceptive or co-cyprindiol (Dianette®). Advise the woman that hirsutism may take 6-9 months (or longer) to improve on hormonal treatment.

    These recommendations are based on guidance from the Royal College of Obstetricians and Gynaecologists [RCOG, 2007] and expert opinion in a review article [Hardiman et al, 2003].
  - Co-cyprindiol should be stopped three or four menstrual cycles after woman's hirsutism has resolved (Committee of Safety Medicines). Other COCs can be continued indefinitely. If relapse occurs after stopping co-cyprindiol, there are different options,
    - Intermittent use of co-cyprindiol, licensed for the treatment of moderately-severe hirsutism.
    - Switching to a COC containing drospirenone (Yasmin®). **Notice that Yasmin is not licensed specifically for hirsutism.**

- Some experts recommend continuing treatment with co-cyprindiol if above measures fail. This may be the best option for otherwise healthy young women

SIDE EFFECTS (acne, headache, depression, weight gain, breast symptoms, and breakthrough bleeding)**:**

- ***BNF 61, Mar-11:***
- The progestogens desogestrel, drospirenone, and gestodene (in combination with ethinylestradiol) may be considered for women who have side effects with other progestogens. See risk of VTE below.

- ***Faculty of Sexual & Reproductive Healthcare Clinical Guidance.*** Contraception Choices for Young People (March 2010): http://www.fsrh.org/pdfs/ceuGuidanceYoungPeople2010.pdf
- Weight gain.
  - There is no evidence of weight gain with combined hormonal contraception (CHC) use.
- Acne.
  - Combined oral contraception (COC) use can improve acne.
  - Young women whose acne fails to improve with COC may wish to consider switching to a COC containing a less androgenic progestogen (**Gedarel, Millinette**) or one with higher estrogen content (**Cilest**).
  - Co-cyprindiol (**Dianette)** is indicated to treat severe acne that has not responded to oral antibiotics. In those with less severe symptoms it should be withdrawn 3-4 months after the condition has resolved. For women with known hyperandrogenism, longer use with specialist review may be warranted.

RISK OF VTE:

- ***BNF 61. Mar-11:***

Incident of VTE in

- Healthy, non-pregnant women who are not taking an oral contraceptive is about 0.5-1 case per 10 000 women per year.
- COC with second generation progestogens (levonorgestrel, **Levest, Microynon 30**) is about 1-2 cases per 10 000 women per year.
- COC with third generation progestogens (desogestrel, **Gedarel**, or gestodene, **Millinette**) is about 2-3 cases per 10 000 women per year.
- Pregnancy is about 6 cases per 10 000 women per year.

- ***MHRA. Drug and Safety Update. June-11:***

Incidence of VTE in:

- COC with Drospirenone (**Yasmin**) is about 3-4 cases per 10 000 women per year.

BNF 7.3.1 COMBINED HORMONAL CONTRACEPTIVES.

Type of preparation	Oestrogen content	Progestogen content	Brand
Monophasic low strength	Ethinylestradiol 20mcg	Desogestrel 150mcg	**Gedarel 20/150**
		Gestodene 75mcg	**Millinette 20/75**
		Norethisterone acetate 1mg	**Loestrin 20**
Monophasic standard strength	Ethinylestradiol 30mcg	Desogestrel 150mcg	**Gedarel 30/150**
		Gestodene 75mcg	**Millinette 30/75**
		Levonorgestrel 150mcg	**Rigevidon**
			Ovranette
			Microgynon 30 or Microgynon 30 ED
		Norethisterone acetate 1.5mg	**Loestrin 30**
	Ethinylestradiol 35mcg	Norgestimate 250mcg	**Cilest**
		Norethisterone acetate 500mcg	**Ovysmen**
		Norethisterone acetate 1mg	**Norimin**
	Mestranol 50mcg	Norethisterone 1mg	**Norinyl-1**

Type of preparation	Oestrogen content	Progestogen content	Brand
Phasic standard strength	Ethinylestradiol 30mcg Ethinylestradiol 40mcg Ethinylestradiol 30mcg	Levonorgestrel 50mcg (6) Levonorgestrel 75mcg (5) Levonorgestrel 125mcg (10)	**TriRegol**
	Ethinylestradiol 35mcg Ethinylestradiol 35mcg Ethinylestradiol 35mcg	Norethisterone 500mcg (7) Norethisterone 1mg (9) Norethisterone 500mcg (5)	**Synphase**

7.3.2 PROGESTOGEN – ONLY CONTRACEPTIVES

Formulation	Progestogen content	Brand
Oral	Levonorgestrel 30mcg	**Norgeston**
	Norethisterone 350mcg	**Micronor**
	Etynodiol diacetate 500mcg	**Femulen**
	Desogestrel 75mcg	**Cerelle**
		Nacrez
Parenteral	Medroxyprogesterone acetate 150mg/ml	**Depo-Provera (1ml prefilled syringe)**

Formulation	Progestogen content	Brand
Intra-uterine system	Levonorgestrel 20mcg/24hours	**Mirena**
Subdermal implantation	Etonorgestrel 68mg	**Nexplanon**

7.3.3 SPERMICIDAL CONTRACEPTIVES

Active Content	Brand
Monoxinol "9" 2%	**Gygel**

7.3.5. EMERGENCY CONTRACEPTION

First Choice	Typical dose	Brand	Second Choice	Typical dose	Brand
Levonorgestrel 1.5mg	1.5mg as a single dose as soon as possible (preferably within 12 hours and no later than 72 hours) after intercourse	**Levonelle 1500**	Ulipristal acetate 30mg	30mg as a single dose between 72 and 120 hours.	**ellaOne**

- If vomiting occurs within 2 hours of taking levonorgestrel or within 3 hours of taking ulipristal, a replacement dose should be given. If an antiemetic is required domperidone is preferred.

BNF 7.4.1 DRUGS FOR URINARY RETENTION, ALPHA-BLOCKERS.

Chronic urinary retention - Benign prostatic hyperplasia:

First Choice	Dose
Tamsulosin Hydrochloride (**modified release capsules**)	400mcg daily

For prescribing information with Male sex hormones and antagonists

6.4.2. **Male sex hormones and antagonists.**

First Choice	Dose
Finasteride	5mg daily

BNF 7.4.2 DRUGS FOR URINARY FREQUENCY AND INCONTINENCE

First Choice	Dose	Second Choice	Dose
Oxybutynin hydrochloride tablets	5mg 2-3times a day ELDERLY: Start with 2.5mg twice a day, increased to 5mg twice a day according to response and tolerance	Fesoterodine fumarate m/r	4mg daily, increased if necessary to 8mg daily
If side effects not tolerated: Oxybutynin hydrochloride XL Tablets	5-10mg daily		

- Review every 4-6 weeks until symptoms stabilise, then every 6-12 months.
- From "Rational Discontinuation of Medicines" (UKMi, NHS East of England, EMEP medicines Efficiency Programme): Discontinue if no valid indication for prescribing, the known possible adverse drug reactions outweigh the possible benefits.

BNF 7.4.5 DRUGS FOR ERECTILE DYSFUNCTION

First Choice	Dose	Second Choice	Dose
Sildenafil	50mg to be taken approx. 1 hour before sexual activity, subsequent doses adjusted according to response to 25-100mg as a single dose. Maximum 1 dose in 24 hours.	Vardenafil	10mg to be taken approx. 25-60minutes before sexual activity, subsequent doses adjusted according to response to maximum 20mg as a single dose. Maximum 1 dose in 24 hours.

- As defined by the BNF and relevant Health Service Circular, treatment for erectile dysfunction is only available on the NHS for men who:
  - have diabetes, MS, Parkinson's Disease, poliomyelitis, prostate cancer, severe pelvic injury, single gene neurological disease, spina bifida or spinal cord injury.
  - are receiving dialysis for renal failure.
  - have had radical pelvic surgery, prostatectomy or kidney transplant.
  - were receiving treatment for erectile dysfunction at the expense of the NHS on 14th September 1998.
- No more than 4 tablets per month should be prescribed.
- Prescriptions should be endorsed with "SLS".

Formulary Chapter 7	**OBSTETRICS, GYNAECOLOGY, AND URINARY-TRACT DISORDERS**
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