Chapter 7: Obstetrics, gynaecology, and urinary tract disorders
Updated: June 2018

The following prescribing guidelines are relevant to the obstetrics, gynaecology, and urinary tract disorders chapter and can be found here:

- Continence appliance prescribing guideline – community formulary
- Continence appliance prescribing guideline – hospital formulary
- Continence product request form, top tips, urinary catheter passport
- Emergency Contraception
- Overactive Bladder - management
- Premature ejaculation - dapoxetine pharmacological management
- Sayana Press - A guide for primary care

7.1 Drugs used in obstetrics
No drug is recommended for this section.

7.2 Treatment of vaginal and vulval conditions
7.2.1 Preparations for vaginal and vulval changes

Ovestin 0.1% (estriol) cream 15g
Vagifem 10microg vaginal tablets 24

7.2.2 Vaginal and vulval infections

Clotrimazole pessaries 200mg (3), pessary 500mg (1), cream 2% 20g, vaginal cream 10% 5g
Fenticonazole pessary 200mg (3), pessary 600mg (1), cream 2% 30g

Imidazole drugs are effective against candida in short courses of 1-14 days according to the preparation used; treatment can be repeated if initial course fails to control symptoms or if symptoms recur. Note-imidazoles damage latex condoms and diaphragms.

7.3 Contraceptives
The Fraser Guidelines should be followed when prescribing contraception for women less than 16 years. The faculty of sexual and reproductive healthcare provides this and other useful information and guidance www.fsrh.org.

Review patients on hormonal contraceptives at least annually for changes in risk factors, personal and family medical history.

Full counselling, backed by the appropriate FPA leaflet, should be provided.

NICE Clinical Guideline 30 recommends:

- women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods;
- contraceptive service providers should be aware that:
  - All currently available LARC methods (intrauterine devices [IUDs], intrauterine system [IUS], injectable contraceptives and implants) are more cost effective than the combined oral contraceptive pill even at 1 year of use.
  - IUDs, IUS and implants are more cost effective than the injectable contraceptives.
  - Increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies.

For advice on interactions between hormonal contraception and other drugs see FSRH guidance.
### 7.3.1 Combined hormonal contraceptives (CHC)

**Ethinyloestriadiol 20 micrograms**

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Contraceptive formulation</th>
<th>Use</th>
<th>Comments and alternative equivalent brands* for information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loestrin 20</td>
<td>Ethinyloestriadiol 20microg norethisterone acetate 1mg</td>
<td>1st line option</td>
<td></td>
</tr>
<tr>
<td>Bimizza</td>
<td>Ethinyloestriadiol 20microg desogestrel 150microg</td>
<td>2nd line option</td>
<td>• Same formulation as Gedarel/Mercilon</td>
</tr>
<tr>
<td>Millinette 20/75</td>
<td>Ethinyloestriadiol 20microg gestodene 75microg</td>
<td>3rd line option</td>
<td>• Same formulation as Femodette/Sunya</td>
</tr>
</tbody>
</table>

**Ethinyloestriadiol 30 micrograms**

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Contraceptive formulation</th>
<th>Use</th>
<th>Comments and alternative equivalent brands* for information</th>
</tr>
</thead>
</table>
| Levest       | Ethinyloestriadiol 30microg levonorgestrel 150microg | A 1st line option in new users | • Same formulation as Rigevidon/Microgynon 30/Maexeni/Eribelle/Elevin  
Or 2nd line option | 2nd line option   | • If oestrogenic side-effects with Brevinor                                          |
| Loestrin 30  | Ethinyloestriadiol 30microg northisterone acetate 1.5mg | 2nd line option |                                                                                  |
| Gedarel 30/150 | Ethinyloestriadiol 30microg desogestrel 150microg | 3rd line option   | • Same formulation as Marvelon/Cimizt/Alenvona/Munalea                                 |

**Ethinyloestriadiol 35micrograms**

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Contraceptive formulation</th>
<th>Use</th>
<th>Comments and alternative equivalent brands* for information</th>
</tr>
</thead>
</table>
| Brevinor     | Ethinyloestriadiol 35microg norethisterone 500microg | First line option | • In new users  
Also useful second line |                                                                                  | • Oestrogen dominant pill  
If suffering progestogenic effects of Rigevidon/Microgynon 30/Ovranette |
| Norimin      | Ethinyloestriadiol 35microg Norethisterone 1mg |                                                                                  |                                                                                  |

*N.B. products are selected by cost-effectiveness as per MIMS June 2018

*New brands of oral contraceptives are constantly being launched and prescribers may find this information helpful in selecting formulary equivalents

1. Appropriate for use up to 50 years of age if no risk factors for CVD, provided a CHC is otherwise suitable. Caution re: risk of VTE with BMI ≥ 30 (contraindicated with BMI ≥ 35). Avoid in women aged over 50. Avoid in smokers aged 35 years and over.

2. There is an increased risk of venous thromboembolic disease in users of combined hormonal contraceptives particularly during the first year and possibly after restarting combined hormonal contraceptives following a break of four weeks or more. This risk is considerably smaller than that associated with pregnancy (about 60 cases of venous thromboembolic disease per 100,000 pregnancies). (BNF online). The MHRA in February 2014 confirmed the small VTE risk of CHCs and recommended that prescribers consider risk factors and remain vigilant for signs and symptoms.

3. The MHRA in March 2014 advised *St John’s Wort interacts with hormonal contraceptives* including implants. This interaction reduces the effectiveness of these contraceptives and increases the risk of unplanned pregnancy.

4. CHCs containing both oestrogen and progestogen are the most effective. A low hormone content pill should be tried initially and the patient maintained on a preparation with the lowest oestrogen and progestogen content consistent with good cycle control and minimal side effects. Preparations containing the older progestogens levonorgestrel and norethisterone are to be preferred.

5. **Phased preparations** are available but they are more complicated to use. They may help to improve cycle control with a lower dose increase in some women, where this is inadequate with a recommended (monophasic) preparation above. These are reserved for women who either do not have withdrawal bleeding or who have breakthrough bleeding with monophasic.

6. Ethinyloestriadiol 30microg/drospirenone 3mg (e.g. Dretine (preferred choice), Lucette, Yasmin are reserved options after above formulaic choices. However the patient should have tried at least two other CHC’s including a third generation one – i.e. containing either Gestodene or Desogestrel.

7. Evra patch is **BROWN** 2nd line to oral formulary CHC. Reserved for women who have demonstrated or are deemed to be at substantial risk of poor compliance with oral CHC. It is significantly more expensive than oral CHC.

8. NuvaRing is **GREEN** after consultant/specialist initiation.
7.3.2 Progestogen only contraceptives:

### Oral progestogen only contraceptives

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Progestogen strength</th>
<th>Use</th>
<th>Comments and alternative equivalent brands* for information</th>
</tr>
</thead>
</table>
| Desogestrel | 75microg             | 1st line | • Cost-effective to prescribe generically  
|            |                      |     | • Brands include Aizea/ Cerazette/ Cerelle/ Desomono/ Desorex/ Zelleta |
| Norgestron | 30microg             | 2nd line |

### Levonorgestrel

#### Norethisterone

| Noriday    | 350microg |

### Parenteral progestogen only contraceptives

#### Etonogestrel

| Nexplanon | 68mg |

#### Medroxyprogesterone acetate (See notes below)

| Depo-Provera | 150mg/ml |
|              |         |
| Sayana Press | 104mg/0.65ml |

#### Norethisterone

| Noristerat | 200mg |

### Intra-uterine progestogen only system

N.b. the health professional should be fully trained in the technique and should provide full counselling backed by the patient information leaflet

#### Levonorgestrel (LNG)

These should always be prescribed by brand name because products have different indication, duration of use and introducers. MHRA Jan 2016

<table>
<thead>
<tr>
<th>Kyleena</th>
<th>Mirena</th>
<th>Jaydess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total LNG content (mg)</td>
<td>19.5 mg</td>
<td>52 mg</td>
</tr>
<tr>
<td>Frame size (W x H)</td>
<td>28 x 30 mm</td>
<td>32 x 32 mm</td>
</tr>
<tr>
<td>Inserter</td>
<td>One handed EviolInserter™</td>
<td></td>
</tr>
<tr>
<td>Insertion tube diameter</td>
<td>3.8mm</td>
<td>4.4mm</td>
</tr>
<tr>
<td>Licensed duration of use for contraception</td>
<td>5 years</td>
<td>5 years</td>
</tr>
<tr>
<td>Licensed for endometrial protection?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Licensed for heavy menstrual bleeding?</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Unit cost (£)</td>
<td>76</td>
<td>88</td>
</tr>
<tr>
<td>Cost per year over period of licensed use (£/year)</td>
<td>15.2</td>
<td>17.6</td>
</tr>
</tbody>
</table>

Information on Intra-Uterine system taken from Faculty of Sexual and Reproductive Healthcare (FSRH) New Product Review: Kyleena 19.5 mg intrauterine delivery system 29 January 2018 (updated 12 February 2018)

1. Levosert is another intra-uterine progestogen only system and has been locally classified BLACK-similar to Mirena but not cost-effective.

### Medroxyprogesterone acetate

Full counselling, backed by manufacturer's approved leaflet, required before administration.

1. In women aged under 18 years progestogen-only injectable contraception can be used after consideration of alternative methods.
2. Women using depot medroxyprogesterone acetate (DMPA) who wish to continue use should be reviewed every 2 years to assess individual situations, and to discuss the benefits and potential risks.
3. In women with risk factors for osteoporosis, a method of contraception other than medroxyprogesterone acetate should be considered.
7.3.3 Spermicidal contraceptives
No recommendations for this section

7.3.4 Contraceptive devices
No recommendations for this section. Seek advice from Sexual Health Services
The most effective intra-uterine devices have at least 380mm² of copper and have banded copper on the arms

7.3.5 Emergency contraception (EC)
All women seeking emergency contraception should be advised that a copper IUD is more effective than emergency hormone contraception (EHC). “A copper IUD (or advice on how to obtain one) should be offered to all women attending for emergency contraception, even if they present within 72 hours of unprotected sexual intercourse” (FSRH 2017) See local Emergency Contraception guideline.

Women should be advised that if they have already ovulated there is no evidence that hormonal emergency contraception has any effect.

Levonorgestrel 1.5mg (Upostelle)
Ulipristal acetate 30mg (EllaOne)
1. Do not prescribe as ‘Levonelle One Step’ as this is the OTC preparation and more expensive.
2. Women using liver enzyme-inducing drugs should be advised that an IUD is the preferred option for Emergency Contraception (Grade A). Women who are using liver enzyme-inducing drugs who are given 1.5 mg tablets of levonorgestrel should be advised to take a total of 3 mg (two tablets) as a single dose, as soon as possible and within 72 hours of unprotected sexual intercourse. This use is outside the product licence. MHRA September 2016
3. For missed pills levonorgestrel is the preferred option.

Quick starting contraception includes:
• Starting contraception at a time other than the beginning of the menstrual cycle, but it is reasonably certain that there is no risk of pregnancy.
• Starting contraception at a time other than the beginning of the menstrual cycle and there is a potential risk of very early pregnancy from recent unprotected sexual intercourse (but it is too early to exclude pregnancy using a high-sensitivity pregnancy test). Quick starting in this situation is appropriate if a woman considers it likely that she will continue to be at risk of pregnancy or if she wishes to avoid delaying commencement of contraception.

After oral emergency contraception, further episodes of unprotected intercourse in the same cycle put women at risk of pregnancy therefore quick starting method is advised.
• After levonorgestrel EC administration, combined oral contraceptives, progesterone only pills, progestogen-only implant (and depot medroxyprogesterone acetate) can be quick started immediately.
• After ulipristal acetate EC administration, they should wait 5 days before quick starting suitable hormonal contraception.

Number of days for abstinence or barrier methods after oral emergency contraception dose:

<table>
<thead>
<tr>
<th>Type of HC</th>
<th>Quick start after ulipristal after 5 day delay</th>
<th>Quick start after levonorgestrel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined oral contraceptive pill (except Qlaira®)</td>
<td>5 day delay +7 days</td>
<td>+7 days</td>
</tr>
<tr>
<td>Qlaira® - combined oral contraceptive pill</td>
<td>5 day delay +9 days</td>
<td>+9 days</td>
</tr>
<tr>
<td>Combined vaginal ring/ transdermal patch</td>
<td>5 day delay +7 days</td>
<td>+7 days</td>
</tr>
<tr>
<td>Progestogen-only pill</td>
<td>5 day delay +2 days</td>
<td>+2 days</td>
</tr>
<tr>
<td>Progestogen-only implant or injectable</td>
<td>5 day delay +7 days</td>
<td>+7 days</td>
</tr>
</tbody>
</table>

7.4 Drugs for genito-urinary disorders
7.4.1 Drugs for urinary retention
Doxazosin tabs 1mg, 2mg, 4mg                     First line
Tamsulosin m/r caps 400 microgram              Second line
Alfuzosin m/r tabs 10mg                        Third line
1. Prescribe tamsulosin m/r capsules rather than the m/r tablets, as these are more cost effective.
2. Doxazosin MR preparation has been classified as **BLACK** as more costly than the immediate release preparation with only marginal benefits in relation to side effects.

3. The combination product tamsulosin 400microg and solifenacin 6mg (Vesomni) has been classified as **BLACK**. Usual dose for solifenacin 5-10mg. Vesomni contains 6mg of solifenacin, swap from individual components not easily achieved. Other combinations of individual products are cheaper than Vesomni.

4. The combination product tamsulosin 400microg and dutasteride 500microg (Combodart) has been classified as **BROWN**. Combodart may be considered if dutasteride is indicated and combination preparation is needed to aid compliance. Finasteride plus tamsulosin is the cost effective option where a combination of an alpha blocker + 5 alpha reductase inhibitor is indicated.

7.4.2 **Drugs for urinary frequency, enuresis, and incontinence**

In urge incontinence, antimuscarinic drugs can reduce contractions and increase bladder capacity.

**Oxybutynin** tabs 2.5mg, 5mg  
**Tolterodine** tablets 2mg  

1. **First line**: Important to titrate the dose slowly

2. Prescribe anticholinergic drugs with caution in older or frail people or people with complex multimorbidities. See relevant resources on anticholinergic drugs / burden, mARS & ACB scale.

3. NICE CG171 advises not to offer oxybutynin immediate release to frail (those with multiple comorbidities, functional impairments such as walking or dressing difficulties and any degree of cognitive impairment) elderly women.

4. If modified release preparation of tolterodine is indicated, the preferred branded generic across Derbyshire is Neditol XL®.

5. Choice of third line agent should take into account possible advantages of specific agents and cost- see also local guidance for the **primary care management of overactive bladder**.

Annual cost of treatment (prices accessed June 2018)

5. **Mirabegron** (NICE TA290) is third line choice after a trial of oxybutynin and tolterodine (tablets 25mg, 50mg), but also see local guidance for the management of overactive bladder.

6. **MHRA Drug Safety Update** in October 2015 issued a safety warning stating mirabegron is contraindicated in patients with severe uncontrolled hypertension (systolic blood pressure ≥180 mm Hg or diastolic blood pressure ≥110 mm Hg, or both). Blood pressure should be measured before starting treatment and monitored regularly during treatment, especially in patients with hypertension.

7. Stress incontinence is generally managed by non-drug methods such as pelvic floor exercises and bladder training.
7.4.3 Drugs used in urological pain
No drug is recommended for this section.
For treatments of minor self-limiting conditions such as mild cystitis patients are encouraged to self-care. Treatments are available to purchase over-the-counter.

7.4.4 Bladder instillations and urological surgery
No drug is recommended for this section.

7.4.5 Drugs for erectile dysfunction
Sildenafil tabs 25, 50, 100mg
1. Sildenafil is the preferred first line treatment option for erectile dysfunction. From 1st August 2014 restrictions on the prescribing of generic sildenafil for erectile dysfunction (ED) have been lifted following new legislation meaning that generically written prescriptions for sildenafil no longer require the annotation “SLS”. However, SLS regulations still apply to Viagra and all other PDE5 inhibitors (branded and generic) for the treatment of ED (see note 5 below).
2. ‘Viagra Connect’ (sildenafil 50 mg film-coated tablets) has been reclassified from a prescription only medicine (POM) to a Pharmacy medicine (P) in November 2017 (see MHRA) due to its favourable and well known safety profile.
   It is indicated for adult men over the age of 18 years with ED, and will be available for suitable patients to purchase from pharmacies without having to consult a doctor. It will not be sold to those with severe cardiovascular disorders; at high cardiovascular risk; liver failure; severe kidney failure; or taking certain interacting medicines. Patients wish to use brand Viagra who do not fit SLS criteria may be advised to purchase OTC.
3. Vardenafil, avanafil and tadalafil are classified as BROWN and are considered to be equally effective; therefore choice should be based on cost:

<table>
<thead>
<tr>
<th>Treatment regime</th>
<th>Annual cost of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sildenafil 50mg (1/wk)</td>
<td>£5.46</td>
</tr>
<tr>
<td>Sildenafil 100mg (1/wk)</td>
<td>£7.67</td>
</tr>
<tr>
<td>Tadalafil 10mg (1/wk)</td>
<td>£27.69</td>
</tr>
<tr>
<td>Tadalafil 20mg (1/wk)</td>
<td>£41.21</td>
</tr>
<tr>
<td>Tadalafil 5mg (OD)</td>
<td>£111.15</td>
</tr>
<tr>
<td>Avanafil 100mg (1/wk)</td>
<td>£183.04</td>
</tr>
<tr>
<td>Vardenafil 10mg (1/wk)</td>
<td>£192.14</td>
</tr>
<tr>
<td>Avanafil 200mg (1/wk)</td>
<td>£284.70</td>
</tr>
<tr>
<td>Vardenafil 20mg (1/wk)</td>
<td>£315.90</td>
</tr>
<tr>
<td>Alprostadil (Caverject Dual Chamber) 10mcg</td>
<td>£382.20</td>
</tr>
<tr>
<td>Alprostadil (Vidal duo) 10mcg</td>
<td>£430.30</td>
</tr>
<tr>
<td>Alprostadil (Caverject vials) 10mcg</td>
<td>£480.48</td>
</tr>
<tr>
<td>Alprostadil 3mg/g (Vitaros)</td>
<td>£520.00</td>
</tr>
<tr>
<td>Alprostadil MUSE 250mcg</td>
<td>£587.60</td>
</tr>
<tr>
<td>Tadalafil 2.5mg (OD)</td>
<td>£714.87</td>
</tr>
</tbody>
</table>

Annual cost of treatment (prices accessed June 2018)
4. Tadalafil once daily preparation (2.5mg, 5mg) has been classified as BLACK as per NHSE guidance.
5. The criteria for NHS prescribing (SLS) are:
   • diabetes, multiple sclerosis, 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 (including transurethral resection of the prostate), or kidney transplant;
were receiving Caverject®, Erecnos®, MUSE®, Viagra®, or Viridal® for erectile dysfunction, at the expense of the NHS, on 14 September 1998; the prescription must be endorsed ‘SLS’
In addition, specialist centres can prescribe PDE-5 inhibitors on the NHS if the man is ‘suffering severe distress as a result of impotence’ that causes:
Significant disruption to normal social and occupational activities
A marked effect on mood, behaviour, social, and environmental awareness
A marked effect on interpersonal relationships.
6. Men should have used six doses of PDE-5 inhibitor at maximum dose (with sexual stimulation) before being classified as non-responder. Consider referring to a specialist in patients who fail to respond to the maximum dose of at least two different PDE-5 inhibitor.
7. The recommended quantity to prescribe is one tablet/appliance a week for most patients, as excessive prescribing could lead to unlicensed, unauthorised and possible dangerous use of these treatments (HSC 1999/148). Prescribe suitable quantity for individual clinical circumstances.
8. Alprostadil (Caverject, Viridal Duo, Vitaros) is **BROWN after specialist initiation.** Alprostadil cream (Vitaros) is recommended for those patients who have failed phosphodiesterase inhibitor treatment and who are unwilling to use alprostadil/invicorp injections.
9. Vacuum pumps are a 2nd line option following treatment with PDE5 inhibitors, after assessment and recommendation by a specialist. JAPC has classified the vacuum pumps as **RED** for new patients – requiring assessment of the condition and training on use of the device for erectile dysfunction as per SLS criteria. See **out of area guidance** for request from outside of Derbyshire.
10. The penile constrictor rings (for use with the vacuum pump) have been classified as **GREEN after specialist initiation.** Constrictor rings vary in price and ring size (£4-£7) and last for approximately 8 uses.
11. Sildenafil has been classified as **RED** for systemic sclerosis (digital ulcers)

### 7.4.6 Drugs for Premature Ejaculation (PE)

For the pharmacological management of PE see **PE guidance.**
The Derbyshire JAPC has classified dapoxetine as **BLACK** (not recommended or commissioned) for the treatment of premature ejaculation.