Derbyshire Medicines Management, Prescribing and Guidelines
DERBYSHIRE PRIMARY CARE FORMULARY

Chapter 7: Obstetrics, gynaecology, and urinary tract disorders
Updated: June 2025

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
- Emergency Contraception
- Overactive Bladder- management
- Sayana Press- A guide for primary care

Relevant Resources:

- NHSI urinary catheter tool
- UHDB obstetric infections antibiotic guideline
- UHDB antenatal care guideline

7.2 Treatment of vaginal and vulval conditions

7.2.1 Preparations for vaginal and vulval changes

Estriol 0.1% cream 15g
Estriol 30 microgram pessary
Estradiol 10microgram vaginal tablets 24

1. Estriol 1mg/g (0.1%) cream and estriol 0.01% cream with each applicator give the same dose due to different applicator sizes. Estriol 0.01% cream is expensive and therefore not on the local formulary. Use estriol 1mg/g (0.1%) cream as more cost effective and smaller amount of cream for each dose.
2. Choice of local oestrogen preparation is based on patient preference to maintain compliance. Estriol 0.1% cream and Estradiol 10mcg pessaries vaginal tablets come with applicator. Vagifem brand is **DNP** (due to more cost-effective preparations being available). It should be noted that different manufacturers of the generic vaginal tablets are supplied with disposable, single-use applicators whilst others are packaged with 2 multiple-use applicators.

Vaginal Moisturiser

Patients should be encouraged to self-care and purchase over the counter when possible. Lubricants may be used by patients who cannot use vaginal oestrogen, e.g. patients with breast cancer. Brands include Hyalofemme, Sylk, Yes, Replens MD. Consideration of cost-effectiveness, ease of use and patient preference should be taken into account.

7.2.2 Vaginal and vulval infections

Fluconazole 150mg capsule
Clotrimazole pessary 500mg (1), cream 1%, 2% 20g
Miconazole cream 2%

1. See CKS for management of vulvovaginal candidiasis- fluconazole 150mg as a single dose is 1st line. If oral treatment contraindicated or not suitable recommend see CKS. If there are vulval symptoms, consider advising on use of a topical imidazole (clotrimazole 1% or 2% cream) in addition. Alternative treatment options include clotrimazole 10% cream, miconazole 2% cream, clotrimazole 200mg pessary.
2. Topical imidazoles preparations may damage latex condoms and diaphragms.

7.3 Contraceptives

Review patients on hormonal contraceptives at least **annually** for changes in risk factors, personal and family medical history. Full counselling, backed by the appropriate patient information leaflet/ resources should be provided. e.g. Family Planning Association (FPA) guides (require free registration), NHS website

NICE Clinical Guideline 30 Long-acting reversible contraception 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.

Other advice

- The Fraser Guidelines should be followed when prescribing contraception for women less than 16 years. The Faculty of Sexual and Reproductive Healthcare (FSRH) provides this and other useful information guidance www.fsrh.org.
- Interactions between hormonal contraception and other drugs- see FSRH guidance.
- Women taking a medicine of teratogenic potential- guidance on contraceptive methods and frequency of pregnancy testing. See MHRA March 2019;
- The Pharmacy Contraception Service (PCS) now allows pharmacists to initiate, and provide ongoing monitoring and supplies of oral contraceptives.

7.3.1 Combined hormonal contraceptives (CHC)

Below are preferred cost-effective choices for oral CHC. Health care professionals should support women to make informed decisions about choosing and using CHC, ensuring that they are informed about contraceptive effectiveness (and how this compares to other contraceptive methods) as well as potential risks and benefits.

Ethinylestradiol 20 micrograms			
Brand Name	**Contraceptive formulation**	**Use**	**Comments and alternative equivalent brands* for information**
Bimizza	Ethinylestradiol 20 microgram desogestrel 150 microgram	1st line option	• Same formulation as Gedarel 20/150, Mercilon
Millinette 20/75	Ethinylestradiol 20 microgram gestodene 75 microgram	2nd line option	• Same formulation as Femodette, Sunya, Akizza 20/75
Ethinylestradiol 30 micrograms			
Levest	Ethinylestradiol 30 microgram levonorgestrel 150 microgram	1st line option in new users	• Review patients at 35 years of age • Useful if require a more progestogen dominant pil • Same formulation as Rigevidon, Ovranette, Microgynon 30, Maexeni, Elevin, Ambelina
		or 2nd line	• If oestrogenic side-effects with Brevinor
Cimizt	Ethinylestradiol 30 microgram desogestrel 150 microgram	2nd line option	• Same formulation as Gedarel 30/150, Marvelon
Millinette 30/75	Ethinylestradiol 30 microgram gestodene 75 microgram	3rd line option	• Same formulation as Katya, Femodene, Akizza 30/75

Ethinylestradiol 35micrograms			
Brevinor	Ethinylestradiol 35 microgram norethisterone 500 microgram	First line option	• In new users • Oestrogen dominant pill
		also useful 2nd line	• If suffering progestogenic effects of Rigevidon, Microgynon 30, Ovranette

N.B. products are selected by cost-effectiveness as per MIMS June 2025
**New brands of oral contraceptives are constantly being launched and prescribers may find this information helpful in selecting formulary equivalents*

1. Appropriate for women up to 50 years of age if no risk factors for CVD, provided a CHC is otherwise suitable. Caution re: risk of venous thromboembolism (VTE) with BMI ≥30. Avoid in women aged over 50. Avoid in smokers aged 35 years and over. Seek advice if BMI ≥ 35.
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). MHRA Feb 2014 confirmed the small VTE risk of CHCs and recommended that prescribers consider risk factors and remain vigilant for signs and symptoms.
3. 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.
4. **Multiphasic 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.
5. Ethinylestradiol 30 microgram + drospirenone 3mg (**GREY).** Patients should have already tried at least two other CHCs including a third generation one – i.e. containing either Gestodene or Desogestrel. Preferred brand is Yacella, which is the same formulation as Lucette and Yasmin.
6. Evra patch is **GREY** 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.
7. Ethinylestradiol + etonogestrel vaginal ring is **GREEN after consultant/specialist initiation**. Brands include NuvaRing and SyreniRing.
8. Be aware that oestrogen-containing hormonal contraceptives and hormone replacement therapy can impair the effectiveness of lamotrigine. (NICE NG217) The risk of using CHC may outweigh the benefit for women using lamotrigine, given the potential risk of reduced seizure control whilst taking CHC and the potential for lamotrigine toxicity in the hormone free interval (HFI). It is advised that alternate contraception should be considered.
9. CHC in patients taking hepatic enzyme inducing drugs- see SPS advice.
   - For women taking enzyme inducers e.g. rifampicin, the preferred method of contraception would be an intrauterine device or an injectable such as medroxyprogesterone.
   - For women taking less potent enzyme inducers e.g. carbamazepine or phenytoin there is some scope to consider other methods instead.
     - For short term use (<2 months) of less potent enzyme inducers, a minimum of 30 micrograms ethinylestradiol pill continuously or tricycle with a shortened 3 or 4 day hormone free interval can be used for the duration of treatment and for a further 28 days (with additional precautions such as the use of condoms).
10. For longer term use of less potent enzyme inducers, a daily dose of at least 50 micrograms of oestrogen should be used (to a maximum of 70 micrograms). This is taken continuously or as a tricycling regimen with a HFI of 4 days for the duration of treatment and a further 28 days. MHRA 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.
11. For guidance on what to do regarding missed doses of CHC see FSRH.

Tailored regimens

Traditional cyclical pill regimens were designed to induce a bleed each month, however the bleed is due to the withdrawal of hormones rather than physiological menstruation. Women should be given information about both standard and tailored CHC regimens. Tailored regimens may be considered in women with troublesome adverse effects such as painful heavy periods and headache during pill free interval. Amend the course length as appropriate. FSRH suggests using one of the following tailored regimens: (note this is off-license and only applies to monophasic 21-day CHC)

Type of tailored regimen	Period of CHC use	Hormone Free Interval
Shortened hormone-free interval (HFI)	21 days (21 active pills or 1 ring, or 3 patches)	4 days
Extended use (tricycling)	9 weeks (3 x 21 active pills or 3 rings, or 9 patches used consecutively)	4 or 7 days
Flexible extended use	Continuous use (>21 days) of active pills, patches or rings until breakthrough bleeding occurs for 3-4 days	4 days
Continuous use	Continuous use of active pills, patches or rings	None

Reference: FSRH Clinical Guideline: Combined Hormonal Contraception (January 2019, amended October 2023) https://www.fsrh.org/Public/Documents/fsrh-guideline-combined-hormonal-contraception.aspx

7.3.2 Progestogen only contraceptives:

Oral progestogen only contraceptives

Brand Name	Progestogen/ strength	Comments and alternative equivalent brands* for information
Desogestrel	**Desogestrel** 75 microgram	• follow the missed pill rules if the pill is taken more than 12 hours late • cost-effective to prescribe generically. • some generics may contain ingredients unsuitable for soya or nut allergy sufferers - these patients should check with the pharmacist when these products are dispensed for allergens. Brands* include Zelleta, Cerelle Brands costing over £5 e.g. Cerazette are classified Do Not Prescribe (**DNP**).
Noriday	**Norethisterone** 350 microgram	follow the missed pill rules if the pill is taken more than 3 hours late
Norgeston	**Levonorgestrel** 30 microgram	follow the missed pill rules if the pill is taken more than 3 hours late

N.B. products are selected by cost-effectiveness as per MIMS June 2025
**New brands of oral contraceptives are constantly being launched and prescribers may find this information helpful in selecting formulary equivalents*

1. Progestogen-only contraceptive pills (Hana and Lovima- desogestrel 75 microgram) have been made available to be purchased over the counter from pharmacies without prescription, increasing choice for women in the ways in which they can access contraception. These should not be provided on a prescription due to being available OTC. See MHRA.
2. Slynd (**GREY**) - Second line progesterone only pill (POP) for people of childbearing potential in whom the desogestrel progestogen only pill (DSG POP) causes intolerable side effects or has an unacceptable bleeding pattern after a trial of 3-6 months and where other methods of contraception including long-acting reversible methods are contraindicated, have been declined, or tried and not suited.

Parenteral progestogen only contraceptives

Brand Name	Progestogen/ strength	notes
Depo-Provera	**Medroxyprogesterone acetate** 150mg/ml	Deep intramuscular injection given at 12 week interval See notes below on medroxyprogesterone. See local guideline
Noristerat	**Norethisterone** 200mg	Deep intramuscular injection given at 8 weeks interval
Sayana Press	**Medroxyprogesterone acetate** 104mg/0.65ml	Subcutaneous injection for patient self-administration at 13-week interval. See local guideline See notes below on medroxyprogesterone
Nexplanon	**Etonogestrel** 68mg	Subdermal implant. Remove within 3 years

1. Etonogestrel (Nexplanon)- MHRA February 2020:amended advice on the insertion site for etonogestrel (Nexplanon) contraceptive implants following concerns regarding reports of neurovascular injury and implants migrating to the vasculature (including the pulmonary artery).
2. Depot Medroxyprogesterone acetate (DMPA) - full counselling, backed by manufacturer's approved leaflet is required before administration.
   - In women aged under 18 years progestogen-only injectable contraception can be used after consideration of alternative methods have been found to be unsuitable or unacceptable. Not recommended for first line contraception due to its effect on bone mineral density
   - Women using (DMPA) who wish to continue use should be reviewed every 2 years to assess individual situations, and to discuss the benefits and potential risks.
   - In women with risk factors for osteoporosis, a method of contraception other than medroxyprogesterone acetate should be considered.
   - MHRA October 2024 – there is a small increased risk of developing meningioma with high-dose medroxyprogesterone acetate (all parenteral preparations and oral preparations containing 100 mg or more), mainly after prolonged use of several years. When used for contraception, high-dose medroxyprogesterone acetate is contra-indicated in patients with meningioma or a history of meningioma—if meningioma is diagnosed, it must be stopped.

Intra-uterine progestogen only system

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

	Levosert	Mirena	Kyleena	Jaydess
Total Levonogestrel (LNG) content (mg)	52mg	52 mg	19.5 mg	13.5 mg
Frame size (W x H)	32 x 32 mm	32 x 32 mm	28 x 30 mm	28 x 30 mm
Inserter	Levosert inserter	One handed EvoInserter™		
Insertion tube diameter	4.8mm	4.4mm	3.8mm	3.8mm
Licensed duration of use for contraception	8 years*	8 years*	5 years	3 years
Licensed for endometrial protection?	No	Yes	No	No
Licensed for heavy menstrual bleeding?	Yes	Yes	No	No
Unit cost (£)	66	88	76	69.22
Cost per year over period of licensed use (£/year)	8.25	11	15.2	23.07

Prices as per MIMS May 2025

Information on Intra-Uterine system taken from Faculty of Sexual and Reproductive Healthcare (FSRH)

*Recommended duration of use for contraception (individuals age ≥45 years at time of insertion) until age 55

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 https://www.yoursexualhealthmatters.org.uk/

7.3.5 Emergency contraception (EC)
All women seeking emergency contraception should be advised that a copper intra-uterine device (Cu-IUD) is more effective than emergency hormone contraception (EHC) and can be inserted into the uterus within 120 hours of unprotected sexual intercourse or up to 5 days after the earliest likely date of ovulation. "A Cu-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 July 2023) 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
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 a Cu-IUD is the preferred option for Emergency Contraception. 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. Levonorgestrel is the preferred option in the event of missed pills.

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:

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

** If EC is considered to be required in the specific situation in which an established CHC user restarts CHC after a hormone-free interval and then misses 2-7 pills in the first week of pill-taking (or makes an equivalent error with combined patch or ring use): See FSRH Quick Starting Contraception statement

- Levonorgestrel emergency contraception may be offered, with **immediate restart of CHC and use of condoms for 7 days**
- if ulpristal acetate emergency contraception is preferred, it may be offered, now with **immediate restart of CHC and use of condoms for 7 days**.

7.4 Drugs for genito-urinary disorders

7.4.1 Drugs for urinary retention

Doxazosin tabs 1mg, 2mg, 4mg	*First line*
Tamsulosin MR caps 400microgram	*Second line*

1. Prescribe tamsulosin MR capsules rather than the MR tablets, as these are more cost effective.
2. Doxazosin MR preparation has been classified as **Do Not Prescribe (DNP)** as more costly than the immediate release preparation with only marginal benefits in relation to side effects. The standard release 8mg tablets are non-formulary due to being less cost effective, if standard release tablets are required other strengths should be prescribed.
3. The combination product tamsulosin 400 microgram and solifenacin 6mg (Vesomni) has been classified as **Do Not Prescribe (DNP)**. 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. Generic tamsulosin 400micrograms + Dutasteride 500micrograms combination product is **GREY** (as more cost effective prescribed individually) Combodart brand is **DNP** as significantly more expensive.

7.4.2 Drugs for urinary frequency, enuresis, and incontinence

See Primary care management of overactive bladder. In urge incontinence, antimuscarinic drugs can reduce contractions and increase bladder capacity.

Solifenacin tabs 5mg, 10mg	1st line
Oxybutynin tabs 2.5mg, 5mg	1st line. Important to titrate the dose slowly

1. Stress incontinence is generally managed by non-drug methods such as pelvic floor exercises and bladder training.
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 NG123 Urinary incontinence and pelvic organ prolapse in women: management advises not to offer oxybutynin immediate release to older women who may be at higher risk of a sudden deterioration in their physical or mental health.
4. Choice of third line agent should take into account possible advantages of specific agents, see local guidance.
5. Mirabegron - 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. Blood pressure monitoring recommendation does not apply to vibegron.

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 OTC.

7.4.4 Bladder instillations and urological surgery

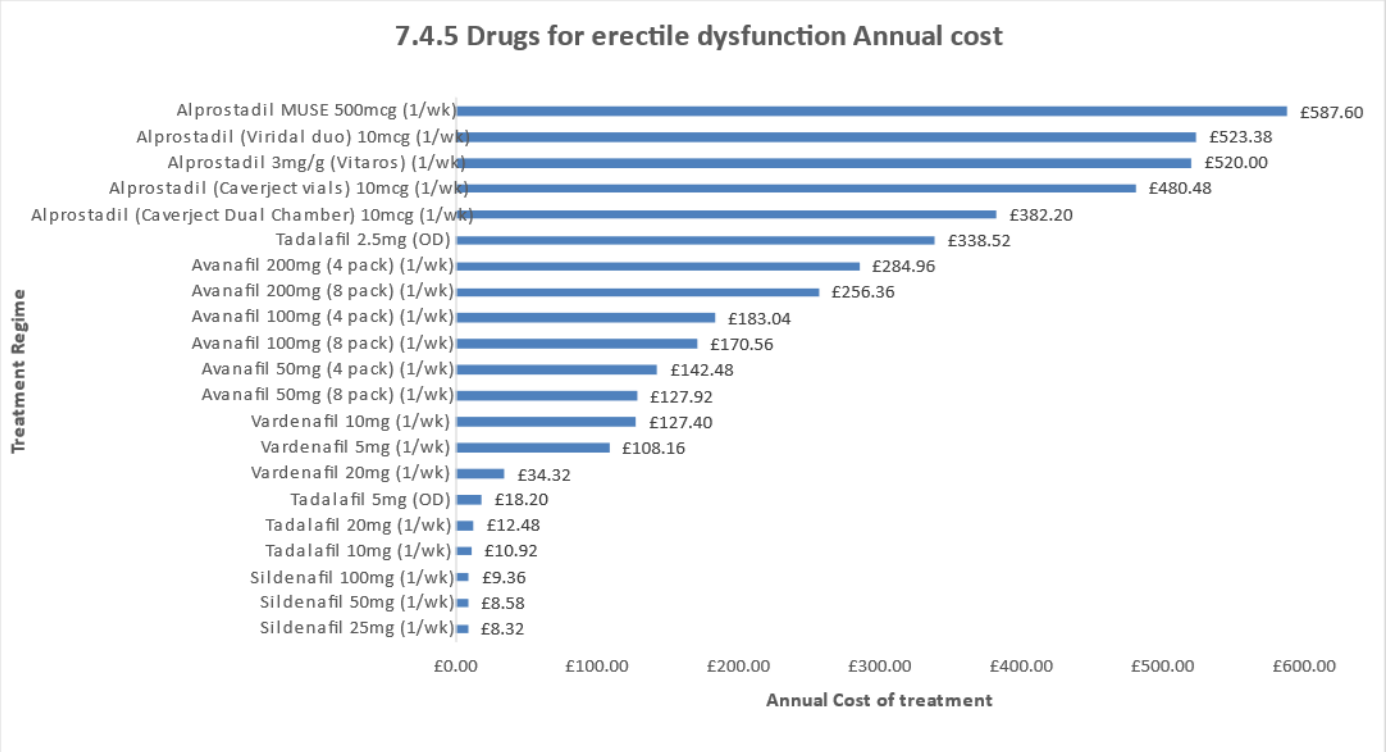
No drug is recommended for this section.

7.4.5 Drugs for erectile dysfunction

Sildenafil tabs 25, 50, 100mg

1. Generic sildenafil is the preferred first line treatment option for erectile dysfunction - "SLS" criteria apply to all other PDE5i. ALL male patients are entitled to NHS treatment for erectile dysfunction with generic sildenafil but only those with certain conditions are entitled to NHS treatment with any of the other treatments including tadalafil. All brands are classified as **DNP**.
2. 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®, MUSE®, Viridal®, Uprima®, Erecnos®, Viagra®, or Cialis® for erectile dysfunction, at the expense of the NHS, on 14 September 1998

   The prescription must be endorsed 'SLS'
3. A number of sildenafil 50mg and tadalafil 10mg products (including Viagra Connect 50mg and Cialis Together) are available for purchase as a pharmacy medicine for use by men aged ≥18 years who have ED. This may be a convenient option for some men. Before making a supply, the pharmacist must ascertain if the OTC route is appropriate. 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 (also those who wish to use Cialis) who do not fit SLS criteria may be advised to purchase OTC. Patients should inform their GP within 6 months of starting an OTC treatment.
4. Vardenafil, avanafil and tadalafil are classified as **GREY** and are considered to be equally effective; therefore, choice should be based on cost (see graph below).
5. Tadalafil 5mg **once daily** preparation for erectile dysfunction (for patients meeting SLS criteria and therefore eligible for NHS prescription) is **GREY** - an option and cost effective when a PDE5 inhibitor requirement for a patient is greater than 8 doses per month.
   Tadalafil 2.5mg **once daily** preparation for erectile dysfunction is **DNP** significantly more expensive compared to other available treatment. It is also classified as **DNP** for benign prostatic hyperplasia.
6. The recommended quantity to prescribe is one per 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.
7. 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 inhibitors.
8. Alprostadil (generic, Viridal Duo, Vitaros) is **GREY 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 seen within Derbyshire – 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-£14) and last for approximately 8 uses.
11. Sildenafil has been classified as **RED** for systemic sclerosis (digital ulcers).



Annual cost of treatment (prices accessed June 2024)

7.4.6 Drugs for Premature Ejaculation (PE)

The Derbyshire JAPC has classified dapoxetine as **Do Not Prescribe (DNP)** (not recommended or commissioned) for the treatment of premature ejaculation. For management of PE see European association of urology guideline. Off-label use of SSRI (e.g. paroxetine, sertraline, fluoxetine) is the treatment of choice. Other treatment options include topical anaesthetic preparations which the BNF advises are available without prescription. Lidocaine + Prilocaine (Fortacin) is **DNP**.