Chapter 7. Obstetrics, gynaecology, and urinary tract disorders

Contents:

For cost information please go to the most recent cost comparison charts

Key

R	**Red drug** see GMMMG RAG list *Click on the symbols to access this list*
A	**Amber drug** see GMMMG RAG list *Click on the symbols to access this list*
Gn	**Green drug** see GMMMG RAG list *Click on the symbols to access this list*
U	If a medicine is unlicensed this should be highlighted in the template as follows **Drug name** U
	Not Recommended
OTC	**Over the Counter**
Order of Drug Choice	Where there is no preferred 1st line agent provided, the drug choice appears in alphabetical order.

BNF chapter	**7 Obstetrics, gynaecology, and urinary tract disorders** For hormonal therapy of gynaecological disorders see section 6.4.1 (including HRT), section 6.5.1 and 6.7.2.	
Section	**7.2 Treatment of vaginal and vulval conditions**	
Subsection	**7.2.1 Preparations for vaginal and vulval changes**	
Oestrogens, topical		
First choice	**Estriol** 0.01% intravaginal cream (Gynest®)	
Alternatives	**Estriol** 500 microgram pessaries (Ortho-Gynest®)	
	Estradiol 10 microgram vaginal tablets (Vagifem®)	
Subsection	**7.2.2 Vaginal and vulval infections**	
Preparations for vaginal and vulval candidiasis		
First choice	**Fluconazole** (see section 5.2) Oral 150mg capsule **Clotrimazole** 500mg pessary	
Alternatives	**Clotrimazole** Thrush cream (topical) 2%, Intravaginal cream 10% VC® **Miconazole Nitrate** 2% cream (Gyno-Daktarin®)	MHRA DSU (June 2016): Topical miconazole, including oral gel: reminder of potential for serious interactions with warfarin
Preparations for other vaginal infections		
First choice	**Metronidazole** Oral 400mg tablet	A dose of 400 mg twice a day for 5 to 7 days is recommended High-dose regimens (single oral dose of 2 g) are not recommended during pregnancy
Alternatives	**Metronidazole** vaginal gel 0.75% **Clindamycin** vaginal cream 2%	

BNF chapter	**7 Obstetrics, gynaecology, and urinary tract disorders**	
Section	**7.3 Contraceptives**	
	Faculty of Sexual & Reproductive Healthcare Guidance NICE PH51: Contraceptive services with a focus of young people up to the age of 25 years NICE LGB17: Contraceptive Services NICE PH3: Prevention of sexually transmitted infections and under 18 conceptions NICE NG73: Endometriosis: diagnosis and management	
Subsection	**7.3.1 Combined hormonal contraceptives (COCs)**	
	When offering combined oral contraceptives first-line options are monophasic preparations containing 30micrograms of oestrogen, and either norethisterone or levonorgestrel. However all combined oral contraceptives can be considered based on patient acceptance. **Other versions of combined oral contraceptives are available and are appropriate to be prescribed.** **The brand with the lowest acquisition cost and greatest ease of acquisition should be prescribed according to local choice.**	
Oral low strength (ethinylestradiol 20mcg)		
	Loestrin 20®, Gedarel®20/150mcg, Milinette® 20/75mcg	
Oral standard strength (ethinylestradiol 30mcg)		
	Levest®, Rigevidon®, Ovranette®, Microgynon 30®, Loestrin 30®	
Oral standard strength (ethinylestradiol 35mcg)		
	Ovysmen®, Brevinor®	
Monophasic (every day) standard strength		
	Microgynon ED®	
Tri-phasic		
	Logynon®	
Transdermal (standard strength)		
	Evra® patches	Evra® is not recommended for routine use, but only for younger, or less compliant women, or those with GI disturbance whilst taking oral contraceptives.

Subsection	**7.3.2 Progestogen-only contraceptives**	
Subsection	**7.3.2.1 Oral progestogen-only contraceptives**	
First choice	**Norethisterone 350 micrograms** (Noriday®)	
Alternatives	**Levonorgestrel 30 micrograms** (Norgeston®)	
	Desogestrel 75 micrograms (Cerelle®, Aizea®)	Cerelle®/Aizea® should not routinely be used as an alternative to COCs but should be reserved for women who have problems adhering to the 3 hour window for other oral progestogen only contraceptives.
Subsection	**7.3.2.2 Parenteral progestogen-only contraceptives**	
	NICE CG30: Long-acting reversible contraception	
Injectable preparations	**Medroxyprogesterone acetate** 150mg prefilled syringe (Depo-Provera®)	
	Medroxyprogesterone acetate 104mg prefilled injector device (Sayana Press®)	
Implants	**Etonogestrel** 68mg implant (Nexplanon® ▼)	MHRA DSU (June 2016): Nexplanon (etonogesterol) contraceptive implants: reports of device in vasculature and lung An implant should only be inserted subdermally and by a healthcare professional who has been appropriately trained and accredited
Subsection	**7.3.2.3 Intra-uterine progestogen-only device**	
	Levonorgestrel 20micrograms/24hours intra-uterine system (Mirena®)	To be implanted by specially trained individuals only. NICE CG44: Heavy menstrual bleeding MHRA DSU: Intrauterine contraception: uterine perforation – updated information on risk factors MHRA DSU: Levonorgesterol-releasing intrauterine systems: prescribe by brand name MHRA DSU: Levonorgestrel-containing emergency hormonal contraception: advice on interactions with hepatic enzyme inducers and contraceptive efficacy
Subsection	**7.3.3 Spermicidal contraceptives**	

	Nonoxinol '9' 2% gel (Gygel®)	
Subsection	**7.3.4 Contraceptive devices**	
Intra-uterine devices		
First choice	**T-Safe® 380A Quickload**	
Alternatives	**Nova-T® 380, Flexi-T® 300**	

Subsection	7.3.5 Emergency contraception	
Faculty of Sexual & Reproductive Healthcare guidelines recommend that all eligible women should be offered the Cu-IUD as it is considered the most effective method of emergency contraception due to the low documented failure rate.		
Hormonal methods		
First choice	**Levonorgestrel** (Levonelle® 1500)	Remains the first choice for those patients that present for emergency contraception before 72 hours after unprotected sexual intercourse or contraceptive failure.
Alternatives	**Ulipristal acetate** (EllaOne®)	NTS recommendation: Ulipristal acetate (EllaOne®) 30mg tabs Recommended as a treatment option only for those patients that present between 72 and 120 hours after unprotected sexual intercourse or contraceptive failure.

BNF chapter	**7 Obstetrics, gynaecology, and urinary tract disorders**	
Section	**7.4 Drugs for genito-urinary disorders** For drugs used in the treatment of urinary tract infections see section 5.1.13 For male sex hormones and antagonists see section 6.4.2 For gonadorelin analogues for prostate cancer see section 8.3.4.2	
Subsection	**7.4.1 Drugs for urinary retention**	
Alpha blockers		
First choice	**Tamsulosin** 400 microgram m/r capsules	NICE CG97: Lower urinary tract symptoms in men
Alternatives	**Alfuzosin** XL 10mg m/r tablets **Doxazosin** 1mg, 2mg and 4mg tablets and 4mg MR tablets	
Parasympathomimetics		
Not recommended		
Subsection	**7.4.2 Drugs for urinary frequency, enuresis, and incontinence**	
First choice drug to be continued for a minimum of four weeks NICE CG171: Urinary incontinence in women NICE CG97: Lower urinary tract symptoms in men GMMMG Treatment of overactive bladder in women		
First choice	**Oxybutynin IR** 5mg tablets **Tolterodine IR** 2mg tablets	Oxybutynin not to be prescribed in frail elderly.
Second choice	**Darifenacin MR** 7.5mg tablets **Trospium MR** 60mg capsules	
Clinicians may want to use alternative agents within first and second choice before progressing to alternatives.		
Alternatives	**Oxybutynin transdermal patch** 36mg (releasing oxybutynin approx. 3.9 mg/24 hours)	NICE CG171: Urinary incontinence in women: Offer a transdermal OAB drug to women unable to tolerate oral medication

	Mirabegron▼ 25mg or 50mg m/r tablets	Mirabegron is only recommended if antimuscarinic drugs are contraindicated or clinically ineffective or have unacceptable adverse effects. MHRA Drug Update 2015: Mirabegron: risk of severe hypertension and associated cerebrovascular and cardiac events. NICE TA290: Mirabegron for treating symptoms of overactive bladder
Additional notes	NICE CG171 concluded that there is a lack of robust evidence to show a difference in clinical effectiveness between OAB drugs. The relative cost effectiveness was determined mostly by the difference in cost between them. NICE concluded that the lack of evidence showing long-term efficacy of OAB therapy should restrict the number of OAB drugs tried before seeking alternative recommended treatments.	
Subsection	**7.4.3 Drugs used in urological pain**	
Alkalinisation of urine		
	Potassium citrate (30%) mixture BP	
Subsection	**7.4.4 Bladder instillations and urological surgery**	
	Glycine irrigation solution **Sodium chloride 0.9%**	
Catheter patency solutions		
	Sodium chloride 0.9% **Solution G** **Solution R**	
Subsection	**7.4.5 Drugs for erectile dysfunction**	
Phosphodiesterase type-5 inhibitors		
First choice	**Sildenafil** 25mg, 50mg and 100mg tablets	Generic sildenafil is no longer subject to selected list scheme (SLS) restrictions and is therefore available for prescribers to prescribe to treat erectile dysfunction (ED).
Alternatives	**Avanafil** ▼ 50mg, 100mg and 200mg tablets	NTS recommendation: Avanafil (Spedra®) for the treatment of erectile dysfunction in adult men
Alprostadil		
Alternative	**Alprostadil** 5microgram, 10microgram, 20microgram and 40microgram injections (Caverject®, Viridal®Duo) 3mg/g cream (Vitaros®)▼	N.B. oral PDE-5 preparations would normally be first line therapy NTS recommendation: Alprostadil (Vitaros®) cream for the treatment of erectile

		dysfunction in adult men
Aviptadil and phentolamine		
Alternative	Solution for intracavernosal injection 25microgram/2mg (Invicorp®)	For those patients who have failed on PDE5 inhibitors and find Alprostadil injections painful
Additional notes:	**Prescribing for erectile dysfunction on the NHS** **BNF/ Drug Tariff approved uses** Except for generic sildenafil, the above drugs are not available on NHS prescription except to treat erectile dysfunction in men who: • have 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; • are suffering severe distress as a result of impotence (prescribed in specialist centres only, see notes below).	
	The prescription must be endorsed 'SLS'. **Severe distress caused by impotence** The Department of Health (England) has recommended that treatment should also be available from specialist services (commissioned by Health Authorities and Primary Care Groups, and operating under local agreement) when the condition is causing severe distress; specialist centres should use form FP10(HP) and endorse it 'SLS' if the treatment is to be dispensed in the community. The following criteria should be considered when assessing distress: • significant disruption to normal social and occupational activities; • a marked effect on mood, behaviour, social and environmental awareness; • a marked effect on interpersonal relationships. Patients should be referred as per local commissioning arrangements.	
Subsection	**7.4.6 Drugs for premature ejaculation**	
Not recommended	NTS recommendation: dapoxetine for premature ejaculation	