NHS Borders
Joint Prescribing Formulary

Obstetrics, gynaecology, and urinary-tract disorders

Black Text	Drugs which may be prescribed by all prescribers
Pink Text	Drugs which are either for specialist only prescription or for specialist initiation, with prescribing transfer to GP

Important Information:

In addition to the disclaimer on NHS Borders website the following information is included confirming that the information contained in NHS Borders Joint Prescribing formulary is drawn from several sources, including BNF & BNF for children, product SPCs, local and national guidelines, local expert opinion, Lothian Joint Formulary and these are all gratefully acknowledged here.

NHS Borders has done its utmost to ensure the information in the BJF is accurate and reliable, but NHS Borders cannot guarantee that the information is complete and accurate. Prescribers are referred to the SPCs, BNF and BNF for children to confirm prescribing information.

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7.1 Prostaglandins and oxytocics

Carboprost (Hemabate)	Injection 150 micrograms/ml • See Labour Ward Guideline
Dinoprostone (Prostin)	Injection 1mg/ml, 10mg/ml Vaginal gel 1mg, 2mg • See Labour Ward Guideline
Ergometrine	Injection 500micrograms/ml • See Labour Ward Guideline
Ergometrine 500micrograms + Oxytocin5units /ml (Syntometrine)	Injection • See Labour Ward Guideline
Oxytocin (Syntocinon)	Injection 5units/ml, 10units/ml • See Labour Ward Guideline
Mifepristone	Tablets 200mg • See Labour Ward Guideline

7.2 Treatment of vaginal and vulval conditions

Preparations for vaginal atrophy

Oestrogens, topical:

- The smallest effective amount should be used
- Treatment course usually 3-6 months

Estriol (Ovestin) or	Intravaginal Cream 0.1% **Dose**: One applicatorful daily for 2-3 weeks, then reduce to twice weekly application. Discontinue every 2-3 months for 4 weeks to assess need for further treatment
Estradiol (Oestrogel)	Pump pack 0.06% gel. **Dose**: Apply 1.5mg (2 measures) once daily continuously; increased after 1 month to 3mg if necessary. • Start within 5 days of menstruation (or anytime if cycles have ceased/are infrequent) • A template is provided to guide application • To be used with cyclical progestogen for at least 12 days of each cycle in women with a uterus
Estradiol (Vagifem)	**Second choice** Vaginal Tablets 10 micrograms **Dose**: One daily for two weeks, then reduce to one vaginal tablet twice weekly. • Discontinue after 3 months to assess the need for further treatment
Estradiol (Estring)	**Alternative product** Vaginal Ring releasing approximately 7.5micrograms/24hours • Replace 3 monthly • Maximum continuous duration of treatment is 2 years

Vaginal and vulval infections

- Refer to BJF Infections chapter

7.3 Contraceptives

7.3.1 Combined hormonal contraceptives (COC)

- A pill containing 30 micrograms oestrogen is recommended for the majority of women
- The risk of breast cancer associated with COC does not appear to be related to the dose of oestrogen
- Combined hormonal contraceptives are associated with a risk of cardiovascular disease and venous thromboembolism (VTE)
- Refer to BNF for advice relating to VTE risk – VTE risk differs with different progestogens
- There is an association between all COC and metabolic changes, including changes in lipids
- Different progestogens have different side-effect profiles associated with their androgenicity
- The effectiveness of oral contraceptives can be affected by antibiotic treatments and also by concurrent use of enzyme-inducing drugs
- For contraindications, refer to the BNF

Standard strength (oral)

Levest	**First choice** Tablets Levonorgestrel 150micrograms + ethinylestradiol 30micrograms • Cost-effective equivalent to Microgynon 30/Ovranette (replacing Rigevidon on formulary)
	Second choices Pills with gestodene or desogestrel (“third generation pills”) may be an appropriate option for women experiencing progestogen-associated side-effects • These pills have an increased risk of VTE • Risks should be discussed
Lizinna	Tablets. Norgestimate 250micrograms + ethinylestradiol 35micrograms • Replacing Cilest on formulary)
Cimizt	Tablets. Desogestrel 150micrograms + ethinylestradiol 30micrograms • Cost-effective equivalent to Marvelon (replacing Gedarel 30/150 micrograms on formulary)
Millinette 30/75 micrograms	Tablets. Gestodene 75micrograms + ethinylestradiol 30micrograms

	• Cost-effective equivalent to Femodene
Co-cyprindiol	Tablets. Cyproterone acetate 2mg + ethinylestradiol 30micrograms. • Prescribers are reminded that co-cyprindiol should not be used solely for contraception, as this is unlicensed use • Contraindicated in those with a personal or close family history of VTE as co-cyprindiol carries increased risk of VTE over other COCs. Women with severe acne or hirsutism may have an inherently increased risk of cardiovascular disease • Licensed for use in women with severe acne which has not responded to oral antibacterials and for moderately severe hirsutism. Should be withdrawn 3-4 cycles after complete resolution of condition, and it may be appropriate to consider one of the least androgenic COC (e.g Cimizt) as ongoing contraceptive treatment

Standard strength (transdermal)

Evra	**Patches** **Dose**: Apply 1 patch weekly for 3 weeks followed by a 7 day patch free interval. Use is restricted to patients who: • Have compliance problems with oral contraceptives i.e. have become pregnant through forgetting to take pill • Are unable to tolerate COC due to nausea • Have absorption problems secondary to inflammatory bowel disease or gastrointestinal surgery

Low strength (oral)

- The lower dose of oestrogen may be an alternative choice for women who experience breast enlargement or mastalgia (oestrogenic side-effects) with the 30 microgram pills

Gedarel 20/150 micrograms	Tablets Desogestrel 150micrograms + ethinylestradiol 20micrograms • Cost effective alternative to Mercilon • See comments above re third generation preparations • Desogestrel is a less androgenic progestogen and may be an appropriate contraceptive choice for women with acne

Low strength (vaginal)

Nuvaring	Vaginal ring **Dose**: 1 ring to be inserted into the vagina, removed on day 22; subsequent courses repeated after 7 day ring-free interval. • Same cardiovascular and VTE risks as other combined hormonal methods

7.3.2 Progestogen-only contraceptives

Progestogen only contraceptives may be more suitable than combined oral contraceptives for:

- Women with diabetes
- Breast-feeding women
- Women with a history of thromboembolism
- Women over 35 (particularly smokers)
- Women with hypertension

Progestogen-only contraceptives (oral)

- A significant proportion of women experience irregular bleeding with POPs. Switching to a different progestogen does not appear to be beneficial

Cerelle	**First choice** Tablets 75micrograms desogestrel • Cost-effective alternative to cerazette • An option for women preferring amenorrhoea or who find a daily tablet easier than managing a pill free week • May be an appropriate choice for less compliant women (including younger women), due to continued contraceptive protection for up to 12 hours after missing a dose (3 hours for other POPs) • Has been shown to inhibit ovulation to a substantially greater extent than other POPs • May be an appropriate choice for women taking a POP who have a history of ectopic pregnancy
Noriday	**Second choice** Tablets 350micrograms norethisterone

Progestogen-only contraceptives (parenteral)

Medroxyprogesterone (Sayana Press)	**First choice** Injection 104mg/0.65ml medroxyprogesterone **Dose**: 104mg by subcutaneous • For long term contraception dose should be repeated every 13 weeks.
Medroxyprogesterone (Depo-provera)	**Second choice** Injection 150mg/ml **Dose**: 150mg by deep intramuscular injection • For long term contraception dose should be repeated every 12 weeks • Associated with weight gain and menstrual dysfunction • Fertility may take up to a year to be fully restored after withdrawal • Associated with reduction in bone mineral density, and should be used in adolescents only when other methods of contraception are inappropriate (CSM warning). See BNF for further information

Long acting reversible contraceptives - Intrauterine systems and sub-dermal implants

Levonorgestrel (Levosert)	**First choice** Intrauterine system. Levonorgestrel 20micrograms/24 hours • Effective for five years • Rapid and apparently complete return to fertility after removal • Associated with amenorrhea and frequent/prolonged spotting
Levonorgestrel (Mirena)	**First line in >45s** Intrauterine system. Levonorgestrel 20micrograms/24 hours • Licensed for endometrial protection (HRT) and prolonged use in >45s)
Levonorgestrel (Kyleena)	Intrauterine system, Levonorgestrel 19.5mg • Effective for up to 5 years • Smaller device and lower dose levonorgestrel • May be an appropriate option for nulliparous women or those preferring lowest dose of hormone

Nexplanon	Subdermal Implant. 68mg etonogestrel (+ 15mg barium sulphate) • Refer to SPC for further information • 50% of women report irregular/prolonged bleeding associated with nexplanon

7.3.3 Spermicidal contraceptives

- These do not give adequate protection when used alone, and are suitable to be used along with a barrier method of contraception

Gygel	Nonoxinol ‘9’ 2%

7.3.4 Contraceptive devices

Intra-uterine contraceptive devices (IUD)

- IUDs containing at least 300mm2 of copper should be used as they have the lowest failure rate
- Pain on insertion of device may be alleviated by a NSAID e.g. Ibuprofen, 30 minutes before insertion
- Take a sexual history from the patient and screen for STIs as appropriate

	First choices • 5 year or 10 year device depending on required duration of contraception
TT380 Slimline	Intra-uterine device • Effective for 10 years. • Easier to load and fit, with a reduced risk of infection at introduction • Tsafe 380 is an alternative preparation
UT380 Short	Intra-uterine device • Effective for 5 years (Included as an option for nulliparous women)
UT380 Standard	Intra-uterine device • Effective for 5 years
Levosert	**Alternative preparation** Intrauterine system. Levonorgestrel 20micrograms/24 hours

	• Effective for five years

Diaphragms

Milex arcing or Milex omniflex	Milex arcing (silicone with arcing spring) or milex omniflex (silicone with coil spring); sizes 60-90mm (rising in steps of 5mm) • Used with careful counselling, only, when other methods of contraception are not appropriate • A spermicide should always be used with a diaphragm

Condoms

- Condoms are the only method of contraception which protects against sexually transmitted diseases, and are available free of charge from Family Planning Services and GP surgeries

7.3.5 Emergency contraception

- Patients should not receive ulipristal and levonorgestrol in the same cycle.
- Hormonal emergency contraception is less effective than insertion of an IUD

	First choice **Copper IUD (choice as above)** • Where this service is available • Within 120 hours of unprotected sexual intercourse or up to 5 days after predicted date of ovulation
Ulipristal	**Second choice** Tablet 30mg **Dose**: One tablet to be taken orally as soon as possible, but no later than 120 hours (5 days) after unprotected intercourse or contraceptive failure. It can be taken at any moment during the menstrual cycle. If vomiting occurs within 3 hours of ulipristal intake, another tablet should be taken. Pregnancy should be excluded before ulipristal is administered. Evidence supports use of ulipristal as first choice “morning after pill” apart from:

	• Patients who require to have a ready supply of the morning after pill for “contraceptive emergency” i.e. those who use condoms alone for contraception, and require a supply of morning after pill in case of burst condom • Patients who have contraindications to ulipristal.ie asthma, treatment with antacids or PPIs; patients with renal or liver impairment • Patients attending GP surgery or family planning clinic for prescription of ulipristal, should also receive advice & supply of condoms + POP/COC • Patients attending OOH for supply of ulipristal should be encouraged to attend GP or family planning clinic for supply of condoms (family planning clinic only) + POP/COC
Levonorgestrel (Emerres)	**Alternative preparation** Tablet 1500 micrograms **Dose**: 1.5mg as a single dose as soon as possible after unprotected intercourse (ideally within 12 hours, but no later than 72 hours). May be used between 72 and 120 hours after unprotected intercourse, but this is unlicensed use and efficacy decreases with time • An alternative preparation for patients who use condoms alone for contraception, and have a supply of morning after pill in case of burst condom • An option for patients who have contraindications to ulipristal. • A replacement dose should be given if vomiting occurs within 2 hours of taking levonorgestrel. Domperidone is the preferred antiemetic if required • Enzyme-inducing drugs reduce the effectiveness of levonorgesterol, and the dose of levonorgesterol should be increased if this is the chosen method of emergency contraception. 1.5mg should be taken immediately and 750micrograms taken 12 hours later. (This dose regime is unlicensed)

7.4 Drugs for genito-urinary disorders

Drugs for urinary retention

Alpha-blockers

- Patients commenced on an alpha-blocker at the urology clinic, are reviewed at the clinic after 3 month
- Full response is expected after 4-6 weeks and there may be some improvement in symptoms after a few days, with benefit likely to be maintained for up to 3 years
- Patients should be aware that the first doses of alpha blocker may be associated with drowsiness and dizziness. If antihypertensive therapy is co-prescribed dose adjustment may be appropriate
- In acute urinary retention associated with benign prostatic hyperplasia in men over 65 years, Alfuzosin 10mg daily is given for 2-3 days during catheterisation and for one day after removal of catheter. Maximum of 4 days for this indication.

Tamsulosin	**First choices** Capsules MR 400micrograms **Dose**: 400micrograms daily as a single dose, after food • Prescribe generically as Tamsulosin MR Capsules • Prescribed off-label for expulsion of distal ureteral stones • Flomaxtra XL is included for specialist initiation (urologist or “falls clinic”) for patients who suffer postural hypotension with generic tamsulosin MR • Vesomni (solifenacin 6mg + tamsulosin 400 micrograms) is approved for use in patients for whom concurrent use of both drugs is appropriate
Alfuzosin	Tablets MR10mg **Dose**: 10mg daily

5 alpha-reductase inhibitors

Finasteride	**First choice** Tablets 5mg **Dose**: 5mg daily • Alternative to alpha-blockers, particularly appropriate for men with a significantly enlarged prostate • Evidence suggests that finasteride reduces the risk of acute urinary retention and the need for surgery.

Dutasteride	**Second choice**
	
	Capsules 500 micrograms
	
	Dose: 500 micrograms daily.
	
	• Initiated by consultant urologist
	• Combodart (combination of Tamsulosin + dutasteride) is approved for use for patients currently receiving treatment with both drugs
	• Use is restricted to men
	  o who are either intolerant of finasteride or
	  o do not respond to finasteride after an adequate trial.

Urological pain

Pentosan polysulfate sodium	Capsules 100mg **Dose**: 100mg three times daily • Specialist initiation and prescription

Drugs for urinary frequency, enuresis and incontinence

Urinary frequency due to unstable bladder

- Drug therapy is not the first line option for patients with urinary frequency, incontinence and urge incontinence – contact the continence team who can provide information to support bladder training
- Therapy should be tried for a period of four to six weeks to enable an assessment of the benefits and side-effects
- A number of therapeutic formulary options are available – patients can have a trial of 3 different anticholinergics before treatment failure
- The need for continuing treatment should be reviewed after 6 -12 months
- Antimuscarinic drugs should be used with caution in the elderly (particularly the frail elderly).

Tolterodine	**First choice (primary care)** Tablets 1mg, 2mg. **Dose**: 2mg twice daily (patients under 60 years of age)1mg twice daily (eGFR < 30ml/min)
Solifenacin	**Second choice (primary care)** Tablets 5mg, 10mg

	Dose: 5mg daily, increased only if necessary to 10mg once daily • Patients who fail to respond after 1 months treatment with solifenacin can be referred to the specialist team at BGH (These patients should take a bladder chart with them to BGH clinic appointment) • Solifenacin is the preferred drug in urge incontinence • Solifenacin is the preferred drug (where drug therapy is indicated) in the elderly • Vesomni (solifenacin 6mg + tamsulosin 400 micrograms) is approved for use in male patients for whom concurrent use of both drugs is appropriate
Oxybutynin or	**Specialist initiation** Tablets 2.5mg, 5mg **Dose**: Initially 2.5mg twice daily (2.5mg daily in the elderly) Maximum dose is 5mg four times daily (5mg twice daily in the elderly) Tablets MR 5mg, 10mg **Dose**: Initially 5mg daily, increased according to response in 5mg steps. Maximum dose is 30mg as a single daily dose, but in practice 10mg daily is the maximum prescribed dose. • Side-effects are common with oxybutynin, particularly in elderly patients, and may be minimised by initiating treatment with a low dose and titrating up gradually. Modified release preparations are generally more favourably tolerated Transdermal 36mg **Dose**: Apply one patch twice weekly. Replacement patches are applied to a different area (avoid using the same area for 7 days) • an option for patients who have established benefit from oxybutynin, but cannot tolerate the side-effects.
Fesoterodine or	Tablets MR 4mg, 8mg **Dose**: 4mg once daily, increased, if necessary to 8mg once daily. Refer to BNF for information on interactions and cautions
Trospium	Capsules MR 60mg **Dose**: 60mg once daily.
	Beta$_3$ agonists

Mirabegron	Tablets 25mg, 50mg **Dose**: • 50mg once daily • 25mg daily in patients: o with mild/moderate renal impairment and/or mild hepatic impairment concomitantly receiving strong CYP3A inhibitor. o with severe renal and/or moderate hepatic impairment.) o Caution in patients with history of QT prolongation or with other medications associated with QT prolongation o Refer to product literature for further information o Specialist initiation for patients who have not responded to/ not tolerated a trial of 2 first or second choice formulary options.

Stress urinary incontinence in women

- Bladder training and exercise are important elements in treatment of stress incontinence – drug treatment may be added to the treatment regime when appropriate
- The NHS Borders Continence Service can be contacted (01896 823809) for advice on referral to specialist services including physiotherapy

Drugs for erectile dysfunction

- Prescribing on the NHS is restricted to the following patient groups with erectile dysfunction:
  - 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 or kidney transplant
  - were receiving Caverject, Erecnos, MUSE, Viagra or Viridal for erectile dysfunction, at the expense of the NHS, on 14 September 1998
  - are suffering severe distress as a result of impotence Scottish government regulations now allow GP SLS prescriptions for phosphodiesterase type-5 inhibitors after a specialist opinion (NHS Borders supports an e-mail service between requesting GPs and urology at BGH) to confirm eligibility due to severe distress. Ensure other possible causes of ED are excluded – refer to Refhelp – Erectile Dysfunction – severe distress assessment form
- Prescription must be endorsed SLS
- GPs may issue private prescriptions for these drugs but may not charge for issuing a private prescription

Sildenafil	**First choice** Tablets 25mg, 50mg, 100mg.

	Dose: Initially 50mg approximately 1 hour before sexual activity, adjusting subsequent doses according to response. Dose range 25-100mg as single dose. Maximum of 1 dose in 24 hours • **Contra-indicated** for men who are receiving nitrates or nicorandil
Tadalafil or	**Second choices** Tablets 10mg, 20mg. 2.5mg, 5mg **Dose**: Initially 10mg at least 30 minutes before sexual activity, adjusting subsequent doses according to response to 20mg as a single dose. Maximum of 1 dose in 24 hours • Tadalafil may be an alternative to sildenafil for patients who develop visual disturbances with sildenafil or for whom a longer duration of action is needed • 2.5mg or 5mg daily dose regimes are specialist initiation (followed by GP prescribing). • **Contra-indicated** for men who are receiving nitrates or nicorandil
Vardenafil	Tablets 5mg, 10mg, 20mg. **Dose**: Initially 10mg (5mg for elderly or adults on alpha-blockers) approximately 25-60 minutes before sexual activity, subsequent doses adjusted according to response up to a maximum of 20mg as a single dose; maximum of 1 dose in 24 hours. • **Contra-indicated** for men who are receiving nitrates or nicorandil
Alprostadil	**Alternative preparations** Dual chamber.10microgram, 20microgram, 40microgram. (Caverject) **Dose**: 2.5-10micrograms after specialist assessment and training. Cream 300 micrograms single use doses. (Vitaros) **Dose**: 300 micrograms. Maximum 1 dose in 24 hours; maximum of 2-3 times per week.