Menstrual Disorders

Also see NICE CG 44 – Heavy Menstrual Bleeding, January 2007
http://www.nice.org.uk/guidance/cg44

General prescribing point

➢ For all menstrual disorders listed below if contraception is also required then a contraceptive should be considered as the 1st choice option.

Dysmenorrhoea

1st Choice
Simple analgesia e.g. Paracetamol, NSAID (excluding Mefenamic Acid)

2nd Choice
Combined Oral Contraceptive
Levonorgestrel (Mirena® IUS)
Medroxyprogesterone Acetate (Depo-Provera®)
Progesterone only pill
Etonogestrel (Nexplanon®)

Prescribing points

➢ To achieve maximal benefits analgesics should be taken regularly, starting just before the anticipated onset of menstruation.

Endometriosis

1st Choice
Simple analgesia e.g. Paracetamol, NSAID (excluding Mefenamic Acid)

2nd Choice
Combined Oral Contraceptive
Levonorgestrel (Mirena® IUS)
Medroxyprogesterone Acetate (Depo-Provera®)
H-Triptorelin (Decapeptyl®)

Prescribing points

➢ Symptoms, particularly pelvic pain and abnormal uterine bleeding, may be better controlled if the combined oral contraceptive is taken continuously for 90 days.
➢ Patients should be advised to use non-hormonal barrier methods of contraception when triptorelin is prescribed.
➢ Side-effects of gonadorelin analogues related to the inhibition of oestrogen production may be reduced hormone replacement (e.g. with an oestrogen and a progestogen or with tibolone).
➢ Levonorgestrel (Mirena®IUS) is recommended off-label for endometrial protection for 5 years use
➢ Women over 45 years of age not using estrogen-only HRT may use for up to 10 years.

Frequent Irregular Periods

Contraception required

1st Choice
Combined Oral Contraceptive or Cerelle®

2nd Choice
Levonorgestrel (Mirena® IUS)
Medroxyprogesterone Acetate (Depo-Provera®)
Progesterone only pill
Etonogestrel (Nexplanon®)

Contraception not required
1st Choice Norethisterone

Menorrhagia

Also see
NICE CG 44 - Heavy Menstrual Bleeding, January 2007
http://www.nice.org.uk/guidance/cg44

| 1st Choice | Tranexamic Acid |
| 1st Choice | Ibuprofen |
| 2nd Choice | Combined oral contraceptive |
|            | Levonorgestrel (Mirena® IUS) |
|            | Medroxyprogesterone Acetate (Depo-Provera®) |

Prescribing points

- NSAIDs / tranexamic acid should be prescribed at an appropriate dose (see BNF) for at least 3 menstrual cycles. Treatment should be continued if patient benefit.
- Patients with menorrhagia and also with dysmenorrhoea should be prescribed NSAIDs in preference to tranexamic acid.
- Women prescribed Mirena® should be informed of potential changes to the bleeding pattern for the first 6 months and advised to persevere for at least 6 cycles to see the benefits of treatment.
- Levonorgestrel IUS should be prescribed by the brand name only.

7.1 - Drugs used in obstetrics

See Labour Ward Guidelines for further details on use of these medicines.

7.1.1 Prostaglandins and oxytocics

| H | Carboprost (Hemabate®) |
| H | Dinoprostone (Prostine E2® , Propess®) |
|   | Ergometrine |
| H | Gemeprost |
| H | Misoprostol vaginal delivery system (Mysodelle®) |
| H | Misoprostol tablets (Cytotec®, off label use) |
| H | Oxytocin (Syntocinon®) |
|   | Syntometrine® |

Prescribing points

- Carboprost (injection) is used to treat post-partum haemorrhage in patients who do not respond to oxytocin.
- Dinoprostone is now the drug of choice for induction of labour. It is usually administered as vaginal gel (Prostin E2®). Propess® is a dinoprostone slow release pessary system used for cervical ripening in patients at term (from 38th week of gestation).
- Ergometrine maleate (injection) is used for the management of post-partum haemorrhage.
- Gemeprost (pessaries) is used to soften and dilate the cervix before induction of abortion.
Misoprostol (Mysodelle®) can be used as an alternative to dinoprostone to induce labour in women with an unfavourable cervix, from the 36th week of gestation. Mysodelle® is more expensive than dinoprostone products but significantly reduces labour time compared to dinoprostone.

Oxytocin (injection) is given by slow intravenous infusion for induction and augmentation of labour. It may also be used in the treatment of post-partum haemorrhage.

Syntometrine® (oxytocin (5 units) and ergometrine maleate (500 micrograms) in 1mL injection) is given by intramuscular injection for the routine management of the third stage of labour. It is also the drug of choice in the management and prevention of post-partum haemorrhage, and for the control of bleeding due to incomplete abortion.

7.1.1.1 Ductus arteriosus

- H - Alprostadil
- H - Ibuprofen injection (Pedea®)

7.1.2 Mifepristone

- H - Mifepristone (Mifegyne®)
- H - Mifepristone + Misoprostol (Medabon®)

Prescribing points

- Mifepristone is indicated as a medical alternative to surgical termination of intra-uterine pregnancy of up to 63 days gestation.
- It may also be used to induce labour following fetal death in utero.
- R - Medabon® is approved for restricted hospital use for the medical termination of developing intra-uterine pregnancy of up to 63 days gestation for early medical discharge termination of pregnancy patients only.
- Mifepristone may be used in combination with misoprostol (off label use of both drugs) in medical terminations between 9 and 24 weeks gestation.

See Termination of Pregnancy Guidelines for further details

7.1.3 Myometrial relaxants

- H - Atosiban (Tractocile®)
- H - Salbutamol injection
- H - Terbutaline injection

Prescribing points

- Atosiban (injection) may be used to delay imminent birth in uncomplicated pre-term labour.

7.2 - Treatment of vaginal and vulval conditions

7.2.1 Preparations for vaginal atrophy

1st Choice - Ovestin® cream (estriol 0.1%)
- Vagifem® vaginal tablets

Prescribing points

- Local oestrogens can improve local vaginal and bladder symptoms caused by oestrogen deficiency; systemic therapy is necessary for vasomotor symptoms.
- Oestrogens may be absorbed systemically from topical preparations. Unopposed topical oestrogen
products should therefore be used at the minimum effective concentration and for the shortest possible time. Attempts to reduce or discontinue treatment should be made at three to six month intervals.

- If they are used on a long-term basis (more than 1 year's continuous use), the addition of an oral progestogen for ten to fourteen days per month should be considered, after specialist advice, to combat endometrial hyperplasia or carcinoma. Patients should be reviewed annually.
- Most women with significant vulvo-vaginal problems will require long-term treatment.
- Gynest® intravaginal cream contains arachis (peanut) oil and is not suitable for patients with peanut allergy. Ovestin® intravaginal cream does not contain arachis oil.
- Vaginal creams may damage latex condoms and diaphragms.
- Estring® is a device that is left in place for 3 months.

7.2.2 Vaginal and vulval infections

Fungal infections

1st Choice

- Clotrimazole
- Fluconazole (oral)

Prescribing points

- Topical azoles are effective in 85-90% of cases.
- A single 500mg clotrimazole pessary is the preferred option for the treatment of fungal infections.
- Pregnancy - clotrimazole is suitable for use in pregnancy. Longer courses are recommended, usually about 7 days. Oral antifungal treatment should be avoided during pregnancy.
- Oral fluconazole in a single dose of 150mg may be used in patients who prefer oral therapy or who have poor compliance with topical treatment.
- Topical azole therapies can cause vulvovaginal irritation and this should be considered if symptoms worsen or persist.
- Condoms and diaphragms - clotrimazole can damage latex condoms and diaphragms.

Other Vaginal Infections

1st Choice

- Metronidazole tablets

2nd Choice

- Dequalinium chloride (Fluomizin®)
- Metronidazole gel 0.75% (Zidoval®)

Prescribing points

- Oral metronidazole (see section 5.1.11) is equally effective and less expensive than the gel formulation. Metronidazole gel should only be used in patients unable to tolerate or comply with oral metronidazole therapy.
- Topical metronidazole and Dequalinium chloride (Fluomizin®) are used 2nd line to treat bacterial vaginosis in patients where a first line treatment is not effective or well tolerated.
- Condoms and diaphragms - clindamycin can damage latex condoms and diaphragms.

7.3 - Contraceptives

Also see Appendix 7B - Quick Reference Guide: Contraceptive Prescribing in Primary Care

KEY:

H - Hospital Use Only
S - Specialist Initiation or Recommendation
R - Restricted Use Only – See Restricted List
General notes

- All women should be informed of long acting reversible methods of contraception (LARC) e.g. copper intra-uterine device (IUD), Mirena® intra-uterine system (IUS), Nexplanon® implant and injectable progesterone (Depo-Provera® 150mg). LARC methods are more cost effective than the combined oral contraceptive pill even at one year of use. These methods should be considered as first choice options for contraception.

- For combined oral contraceptives (COC) a product containing 30-35 micrograms of oestrogen with a low dose of either levonorgestrel or norethisterone is a suitable first line option. Different doses of oestrogen may be associated with different side-effect profiles in individual women.

- All COCs are associated with metabolic changes, particularly in lipids. While pills containing desogestrel, gestodene and norgestimate are associated with fewer adverse effects on lipids there is no evidence that this has any clinical benefit.

- No additional contraceptive precautions are required when combined oral contraceptives or oral progestogen-only preparations are used with antibiotics that do not induce liver enzymes, unless diarrhoea or vomiting occurs.

7.3.1 Combined Hormonal Contraceptives
Also see Faculty of Sexual & Reproductive Healthcare (FSRH) Clinical Guidance
www.fsrh.org/pages/clinical_guidance.asp

<table>
<thead>
<tr>
<th>Levonorgestrel or norethisterone containing preparations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Choice</td>
</tr>
<tr>
<td>Rigevidon® (Equivalent to Microgynon 30® and Ovranette®)</td>
</tr>
<tr>
<td>2nd Choice</td>
</tr>
<tr>
<td>Clique® (Equivalent to Cilest®)</td>
</tr>
<tr>
<td>Loestrin 20®</td>
</tr>
<tr>
<td>Loestrin 30®</td>
</tr>
<tr>
<td>Gedarel® (20/150) (Equivalent to Mercilon®)</td>
</tr>
<tr>
<td>Gedarel® (30/150) (Equivalent to Marvelon®)</td>
</tr>
<tr>
<td>Millinette® (20/75) (Equivalent to Femodette®)</td>
</tr>
<tr>
<td>Millinette® (30/75) (Equivalent to Femodene®)</td>
</tr>
<tr>
<td>R-Triregol® (Equivalent to Logynon®)</td>
</tr>
</tbody>
</table>

Prescribing points

- If side effects are a problem with 2nd generation pills then a 3rd generation pill can be tried. There is an increased risk of VTE with any combined oral contraceptive but the risk is higher with the 3rd generation combined pills. However, overall, the absolute risk is very small.

- R-Triregol® tablets and Evra® patches are approved for restricted use only, in patients when 1st, 2nd or
3rd choice pills have been not tolerated or are unsuitable.

- Yasmin® and Qlaira® have not been approved by the SMC and should not be prescribed routinely in NHS Fife. No new patients should be prescribed Yasmin® or Qlaira® unless a Peer Approved Clinical System (PACS2) Request Form / SMC Non Submission Treatment Request Form has been approved.

7.3.2 Progesterone only contraceptives
Also see Faculty of Sexual & Reproductive Healthcare (FSRH) Clinical Guidance
www.fsrh.org/pages/clinical_guidance.asp

7.3.2.1 Oral progesterone-only contraceptives

Oral progesterone-only contraceptives

1st Choice

<table>
<thead>
<tr>
<th>Norethisterone 350mcg (Noriday®)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desogestrel 75mcg</td>
</tr>
<tr>
<td>(Cerelle® - Equivalent to Cerazette®)</td>
</tr>
</tbody>
</table>

Prescribing points

- Women prescribed progesterone only pills (POPs) should receive counselling and reinforcement that a good pill taking routine is necessary.
- Cerelle® is the preferred option when prescribing progestogen-only contraception for young patients or those who are poor compliers due to the 12 hour window for taking the next pill.

7.3.2.2 Parenteral progesterone-only contraceptives
Also see Ni CE CG 30 - Long-Acting Reversible Contraception, October 2005
www.nice.org.uk/cg030

Injectable preparation

<table>
<thead>
<tr>
<th>Medroxyprogesterone acetate</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Depo-Provera®) - IM injection</td>
</tr>
<tr>
<td>Medroxyprogesterone acetate</td>
</tr>
<tr>
<td>(Sayana Press®) - SC injection</td>
</tr>
</tbody>
</table>

Implant

| Etonogestrel (Nexplanon®) |

Prescribing points

- All women should be informed of long acting reversible methods of contraception (LARC) e.g. copper intra-uterine device (IUD), Mirena® intra-uterine system (IUS), Nexplanon® implant and injectable progesterone (Depo-Provera® 150mg). LARC methods are more cost effective than the combined oral contraceptive pill even at one year of use. These methods should be considered as first choice options for contraception.
- In women of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out in those who wish to continue use of Depo-Provera® for more than 2 years -
  - Due to Depo-Provera®’s potential to cause a reversible reduction in bone mineral density, the Faculty of Sexual and Reproductive Health (FSRH) advises that Depo-Provera® can be used in adolescents when other methods of contraception are unacceptable or unsuitable.
  - In women with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered.

KEY:-

H - Hospital Use Only
S - Specialist Initiation or Recommendation
R - Restricted Use Only – See Restricted List

Fife Formulary
December 16
Last amended Sept 19
Nexplanon® insertion and removal requires specialist training.

Return of fertility may be delayed after stopping treatment with Depo-Provera® but not after using Nexplanon®.

### 7.3.2.3 Intra-uterine progesterone - only systems

Also see NICE CG 30 - Long-Acting Reversible Contraception, Updated September 2014
www.nice.org.uk/cg030

<table>
<thead>
<tr>
<th>1st Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levonorgestrel 52mg (Mirena® IUS)</td>
</tr>
<tr>
<td>Levonorgestrel 19.5mg (Kyleena® IUS)</td>
</tr>
</tbody>
</table>

#### Prescribing points

- **Levonorgestrel IUS should be prescribed by the brand name only.**
- All women should be informed of long acting reversible methods of contraception (LARC) e.g. copper intra-uterine device (IUD), Mirena® intra-uterine system (IUS), Kyleena® IUS, Nexplanon® implant and injectable progesterone (Depo-Provera® 150mg). LARC methods are more cost effective than the combined oral contraceptive pill even at one year of use. These methods should be considered as first choice options for contraception.
- Women wishing to use intrauterine contraception should undergo risk assessment for sexual transmitted infections (STIs) and if appropriate should be offered testing for STIs.
- Insertion of the Mirena® IUS and Kyleena® IUS requires specialist training.
- Kyleena® IUS is licensed for use for 5 years (Mirena® IUS 5 years).
- Kyleena® IUS has a slightly shorter, narrower frame and a narrower insertion tube when compared with Mirena® IUS. Some clinicians may find it easier to fit in young and nulliparous women.
- The following points only apply to the Mirena® IUS:-
  - Mirena® IUS has a beneficial effect on dysmenorrhoea and menorrhagia and is licensed for the management of menstrual problems.
  - Mirena® IUS is also licensed to provide the progestogen component of HRT, but the manufacturer advises replacement after 4 years for this indication. This also applies if Mirena® IUS is used for contraception as well as to provide the progestogen component of HRT.
  - Fertility declines with age and therefore a Mirena® IUS inserted in women over the age of 45 may usually be retained for up to 7 years (off-label use). Refer to latest FSRH guidance.

#### 7.3.3 Spermicidal contraceptives

| Nonoxinol ‘9’ 2% (Gygel®) |

#### Prescribing points

- Barrier methods such as diaphragms, caps and condoms have comparatively higher failure rates than systemic methods of contraception or intrauterine devices. Women wishing to use barrier methods as the sole method of contraception should be made aware of this.
- Spermicidal contraceptives are useful safeguards for use with barrier methods but do not give adequate protection when used alone.
- The concomitant use of condoms should be encouraged to prevent sexually transmitted infections.

#### 7.3.4 Intra-uterine contraceptives

KEY:-

- **H** - Hospital Use Only
- **S** - Specialist Initiation or Recommendation
- **R** - Restricted Use Only – See Restricted List
1st Choice

TT 380® Slimline
(For uterine length 6.5cm to 9cm; replace every 10 years)

2nd Choice

UT 380 Standard® (Equivalent to Nova® T 380)
(For uterine length 6.5cm to 9cm; replace every 5 years)

Mini TT 380® Slimline
(For minimum uterine length 5cm; replace every 5 years)

UT 380 Short®
(For uterine length 5cm – 7cm; replace every 5 years)

Prescribing points

- All women should be informed of long acting reversible methods of contraception (LARC) e.g. copper intra-uterine device (IUD), Mirena® intra-uterine system (IUS), Nexplanon® implant and injectable progesterone (Depo-Provera® 150mg). LARC methods are more cost effective than the combined oral contraceptive pill even at one year of use. These methods should be considered as first choice options for contraception.

- Women wishing to use intrauterine contraception should undergo risk assessment for sexual transmitted infections (STIs) and if appropriate should be offered testing for STIs.

- Insertion of copper intra-uterine devices requires specialist training.

- A copper IUD can be inserted up to 120 hours (5 days) after unprotected sexual intercourse for emergency contraception or up to 5 days after the earliest predicted ovulation.

- The most effective copper IUDs have at least 380mm² of copper and are banded, i.e. have copper on the arms as well as the stem. However unbanded devices with copper on the stem only are slightly easier to fit and may need to be considered if the cervix is very narrow.

- Fertility declines with age and therefore a copper IUD which is fitted in women over the age of 40 may usually be retained until the menopause. Refer to latest FSRH guidance.

7.3.5 Emergency contraception

Prescribing points

- It must be borne in mind that the most effective method of emergency contraception is a copper IUD which can be fitted up to 5 days after unprotected sex or up to 5 days after the earliest predicted ovulation. The IUD can then be retained as an ongoing method of long-lasting contraception.

- Ulipristal acetate is the most effective hormonal emergency contraception (EC). Consider as 1st line if unprotected sexual intercourse (UPSI) was 96 – 120 hours ago, or if UPSI was in the 5 days prior to ovulation.

- Ulipristal can be used at standard dose if weight is greater than 70kg or BMI greater than 26.
Levonorgestrel should be considered as 1st line hormonal EC if UPSI is unlikely to have occurred in a fertile period and quick starting of ongoing hormonal contraception is planned.

Levonorgestrel is licensed for use within 72 hours of intercourse.

Levonorgestrel dose must be doubled if weight is greater than 70kg or BMI greater than 26.

There is evidence to suggest that the sooner levonorgestrel is used, the more likely it is to be effective.

Upostelle® is cheaper than Levonelle® and is the preferred Fife Formulary choice.

Some medications can reduce the effectiveness of levonorgestrel or ulipristal. Please refer to the BNF or Summary of Product Characteristics (SPC) for further details.

7.4 - Drugs for genito-urinary disorders

**Drugs for Urinary Retention**

Also see
Appendix 7D - Lower Urinary Tract Symptoms Pathway

**NICE CG 97 - Management of Lower Urinary Tract Symptoms in Men, May 2010**

http://www.nice.org.uk/guidance/CG97

**7.4.1 Alpha-blockers**

<table>
<thead>
<tr>
<th>1st Choice</th>
<th>2nd Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tamsulosin M/ R 400mcg Capsules</td>
<td>Alfuzosin M/ R 10mg</td>
</tr>
</tbody>
</table>

**Prescribing points**

- Watchful waiting may be preferable to treatment in patients with mild to moderate symptoms and who are experiencing no significant impact on quality of life (IPSS tool).
- Alpha-blockers are the drug treatment of choice and are likely to provide symptom relief in men with prostates of any size. The effect should be noticed within a few days, with full response after 4 to 6 weeks.
- Alpha-blockers relax smooth muscle in benign prostatic hyperplasia (BPH) improving obstructive symptoms and urinary flow rate.
- Alpha-blockers may cause dizziness and drowsiness with the first few doses. Tolerance to these effects will occur.
- For information on the co-prescribing of alpha-blockers and phosphodiesterase inhibitors for erectile dysfunction see section 7.4.5.
- Tamsulosin capsules are more cost effective than the tablet formulation.
- Tamsulosin may be prescribed 'off-label' as short term therapy to enhance medical expulsion of ureteral stones. Specialist recommendation only.

**5α reductase inhibitors**

<table>
<thead>
<tr>
<th>1st Choice</th>
<th>2nd Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finasteride</td>
<td>S - Dutasteride (Avodart®)</td>
</tr>
</tbody>
</table>

**Prescribing points**

- 5α-reductase inhibitors are used in the treatment of BPH. They reduce prostate size, reducing obstructive symptoms and increasing urinary flow rate.
- 5α-reductase inhibitors are normally used in men with an enlarged prostate or severe symptom. They

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**KEY:**

H - Hospital Use Only
S - Specialist Initiation or Recommendation
R - Restricted Use Only – See Restricted List

Fife Formulary December 16
Last amended Sept 19
may also be recommended when alpha-blockers are ineffective, contra-indicated or not tolerated.

- Treatment should be continued for at least 4-6 months to obtain benefits. It may take up to one year for treatment to have maximum effect and patients may require long-term treatment.
- A combination of an alpha blocker and 5α-reductase inhibitor may be used for severe symptoms when benign prostatic enlargement is the most likely cause of symptoms.
- Combodart® (dutasteride + tamsulosin) should only be prescribed in patients when a combination of finasteride + tamsulosin is unsuitable/ineffective.

## 7.4.2 Drugs for urinary frequency, enuresis and incontinence

Also see
SIGN 79 – Management of Urinary Incontinence in Primary Care, December 2004

NI CE CG 171 - Urinary incontinence - The management of urinary incontinence in women, September 2013

### Urge Incontinence

<table>
<thead>
<tr>
<th>1st Choice</th>
<th>2nd Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tolterodine (standard tablets)</strong></td>
<td><strong>Solifenacin (Vesicare®)</strong></td>
</tr>
<tr>
<td><strong>R - Mirabegron (Betmiga®)</strong></td>
<td><strong>H - Botulinum toxin type A 50, 100, 200 units/ vial (Botox®)</strong></td>
</tr>
</tbody>
</table>

### Prescribing points

- Drugs used to treat urinary frequency and incontinence should be used along with non-drug measures, including pelvic floor muscle exercises, bladder retraining, monitoring fluid intake and lifestyle changes.
- Patients’ response to drugs within this class is idiosyncratic. It may be necessary to try different drugs before a response occurs.
- The need for continuing drug therapy should be reviewed every 4-6 weeks until symptoms stabilise then every 6-12 months.
- M/R tolterodine is significantly more expensive than standard tablets. The M/R version should be avoided in hepatic and renal impairment.
- Most patients will respond to solifenacin 5mg, which should be trialled for 6-8 weeks before considering a dose increase to 10mg.
- R - Mirabegron is approved for restricted use as a 3rd choice option. Restricted to patients in whom 1st and 2nd choice formulary antimuscarinics are ineffective, not tolerated or contraindicated.
- Mirabegron has been shown to be less likely to cause dry mouth than tolterodine, overall discontinuation rates with mirabegron are similar to tolterodine. There is no trial evidence to suggest mirabegron is more effective than antimuscarinics.
- H - Botulinum toxin type A 50, 100, 200 units/vial (Botox®) is approved for restricted hospital use only for the management of urinary incontinence in patients with spinal cord injury or MS. Restricted to use when other oral alternatives have been ineffective.
- If formulary choice drugs are ineffective or not tolerated then alternative products can be considered before referring to urology for further assessment.

### KEY:

- **H** - Hospital Use Only
- **S** - Specialist Initiation or Recommendation
- **R** - Restricted Use Only – See Restricted List
**Stress Incontinence**

Also see

NICE CG 40 - Urinary incontinence - The management of urinary incontinence in women, October 2006

http://www.nice.org.uk/guidance/cg40

<table>
<thead>
<tr>
<th>1st Choice</th>
<th>Pelvic floor muscle exercises</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd Choice</td>
<td>Duloxetine (Yentreve®)</td>
</tr>
</tbody>
</table>

**Prescribing points**

- Pelvic floor exercises are considered the first line treatment for stress incontinence in women.
- Duloxetine is restricted to use, by the Scottish Medicines Consortium (SMC), in moderate to severe stress incontinence in women as part of an overall management strategy in addition to pelvic floor muscle exercises.
- NICE CG 40 states that duloxetine should not be used as a 1st line treatment for stress urinary incontinence. It should not be routinely used as a 2nd line treatment but may be offered as an alternative to surgical treatment.
- Patients should be reviewed after 4 weeks and again after twelve weeks of therapy to determine whether it is appropriate to continue treatment.

**Nocturnal enuresis**

Also see

NICE CG 111 – Nocturnal Enuresis, October 2010

http://www.nice.org.uk/guidance/CG111

<table>
<thead>
<tr>
<th>Desmopressin tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desmomelt®</td>
</tr>
<tr>
<td>S - Imipramine</td>
</tr>
</tbody>
</table>

**Idiopathic nocturnal polyuria**

Desmopressin lyophilisate (Noqdirna®)

**Prescribing points**

- Desmopressin lyophilisate (Noqdirna®) is recommended for symptomatic nocturia due to idiopathic nocturnal polyuria in patients aged over 65 yrs of age.
- Patients should be reviewed at 3 months to ensure a response was achieved. If there has been no response treatment should be discontinued.
- Strength is gender specific.
  * 25mcg strength is for female patients
  * 50mcg is for male patients.
**Renal Colic**

1st Choice

Diclofenac (IM injection)

2nd Choice

Morphine

**Prescribing points**

- Diclofenac tablets can be used in patients who are not experiencing nausea and vomiting. Diclofenac by intramuscular injection may be used for pain relief in renal colic where the rectal route is unsuitable. See chapter 10.1.1. for further information on the appropriate prescribing of diclofenac.

- Morphine may be used in patients who are unable to use diclofenac. See section 4.7.2 for further information.

### 7.4.3 Drugs used in urological pain

#### Alkanisation of Urine

Potassium citrate mixture

**Prescribing points**

- Potassium citrate may relieve discomfort in mild urinary tract infections.

- Potassium citrate should be used with caution in the elderly as it may lead to hyperkalaemia if used for prolonged periods at high dosages.

### 7.4.4 Bladder instillations and urological surgery

#### Dissolution of encrustation in catheter

Solution G

#### Dissolution of blood clots following urological surgery

Sodium chloride 0.9%

H - Glycine

**Prescribing points**

- Sodium chloride 0.9% is used when a purely mechanical effect is needed to help remove small blood clots and tissue debris and reduce the number of micro-organisms. It is used for flexible cystoscopies.

- Solution G (citric acid 3.23%, magnesium oxide 0.38%, sodium bicarbonate 0.7%, disodium edetate 0.01%) is used in the removal of crystallisation in the catheter or bladder.

- Glycine 1.5% irrigation solution is the irrigation of choice during transurethral resection of the prostate gland and bladder tumours.

### Painful bladder syndrome/Interstitial cystitis

1st Choice

H - Sodium hyaluronate (Cystistat®)

2nd Choice

H - Sodium chondroitin sulphate (Uracyst®)

H - Sodium hyaluronate/ sodium chondroitin sulphate (Ialuril®)

**KEY:**

H - Hospital Use Only

S - Specialist Initiation or Recommendation

R - Restricted Use Only – See Restricted List

Fife Formulary

December 16

Last amended Sept 19
Treatment of or prevention of recurrence of bladder tumours

H - BCG (bacillus calmette-guérin) bladder instillation (ImmuCyst®/Oncotice®)

H - Mitomycin-C
(Mitomycin C Kyowa®, Mito-In®)

7.4.5 Drugs for erectile dysfunction

Also see Appendix 7A - Patient Pathway: Erectile Dysfunction Assessment in Primary Care

Drug treatments for erectile dysfunction may only be prescribed on the NHS under certain circumstances - see http://www.sehd.scot.nhs.uk/pca/PCA1999(M)09(P)03.pdf and for patients with severe distress http://www.sehd.scot.nhs.uk/pca/PCA2011(M)04.pdf

Phosphodiesterase type-5 inhibitors (PDE5i)

1st Choice
Sildenafil SLS
Tadalafil 10mg,20mg (Cialis®) SLS
R - Vardenafil (Levitra®) SLS

2nd Choice
S - Alprostadil [Caverject® Dual Chamber (2.5-20mcg), Viridal Duo (20mcg-40mcg)] SLS
S - Alprostadil cream (Vitaros®)
S - Alprostadil urethral sticks (Muse®)

Prescribing points

- Prescribers are advised to prescribe one treatment per week (4 tablets per month) for most patients. The prescriber, in exercising their clinical judgement, may prescribe a larger quantity where they feel it is appropriate.
- Drugs for erectile dysfunction can only be prescribed under circumstances on the NHS. For further details see Appendix 7A and http://www.sehd.scot.nhs.uk/pca/PCA1999(M)09(P)03.pdf
- GPs can issue private prescriptions for the above drugs for patients on their list who do not qualify for NHS treatment. The GP cannot charge patients for issuing a private prescription.
- Patients should have tried maximum tolerated doses of two different oral treatments for a minimum of 8 doses each, before referring them to Urology for consideration of other non oral therapies e.g. transurethral or intracavernosal alprostadil or vacuum devices. Psychosexual counselling should also be considered.
- Sildenafil and tadalafil are contra-indicated in patients receiving both short and long acting nitrates, nicorandil and also in patients taking amyl nitrate (‘Poppers’).
- In patients co-prescribed alpha-blockers, tadalafil should be avoided due to an enhanced hypotensive effect. There should be at least a 4 hour gap between taking sildenafil and the alpha-blocker and at least a 6 hour gap for vardenafil.
- Patients taking tadalafil on demand (10mg/20mg) should be switched to the daily tablet (2.5mg/5mg) if the frequency of use is at least twice weekly. It should be noted that the maximum dose for daily tadalafil is 5mg once daily.
- R - Vardenafil (Levitra®) is approved for restricted use only. In patients where sildenafil has been ineffective and the patient is being co-prescribed an alpha-blocker.

KEY:-

H - Hospital Use Only
S - Specialist Initiation or Recommendation
R - Restricted Use Only – See Restricted List
- Alprostadil can be administered as an alternative to oral treatments. For doses up to 20mcg the preferred formulation is Caverject® Dual Chamber. For higher doses the recommended formulation is Viridal Duo®.
- Avanafil (Spedra®) is not approved for the treatment of erectile dysfunction by the SMC. Requires submission and approval of a PACS2 Request Form before prescribing.