Obstetric and gynaecological disorders

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For full information on treatment side effects, cautions and contraindications, see electronic British National Formulary (www.bnf.org) or the relevant summary of product characteristics (www.medicines.org.uk).

For information on preparing intravenous medicines for administration, see Medusa Injectable Medicines Guide for the NHS (see Clinical Guidance home page)

1. Eclampsia and pre-eclampsia

Severe pre-eclampsia and eclampsia are life-threatening conditions. They must be managed by the obstetric team.

NOTE: Always inform a Consultant Obstetrician and Anaesthetist

Treatment consists of:
   i) Control of blood pressure using labetolol
   ii) Control / prevention of seizures using magnesium
   iii) Fluid management

See Wirral Women and Children’s Hospital Guideline 12 Pre-eclampsia and Eclampsia for information on how to treat pre-eclampsia and eclampsia, how to prepare and administer medications and monitoring requirements.
2. Loss or termination of pregnancy (medical management)

See Wirral Women and Children’s Hospital Guideline 1 Pregnancy Loss and Medical Termination of Pregnancy — Summary of medical management).

Supplementing this document are the following guidelines, which relate to specific periods of pregnancy:

- Miscarriage — Management in first trimester
- Miscarriage — Medical management in second trimester (13–22 weeks)
- Termination of pregnancy after 22 completed weeks

NOTE: Termination of pregnancy should ONLY be conducted under the supervision of a consultant obstetrician and ONLY on the Wirral Women and Childrens Hospital unit.

3. Vaginal and vulval infections

Conditions include:
- i) Vaginal candidiasis
- ii) Candidal vulvitis (invariably associated with vaginal candidiasis)

i) Vaginal Candidiasis

First choice
Fluconazole 150mg, orally, as a single dose

Second choice
Clotrimazole 500mg, as a pessary, once at night

ii) Candidal vulvitis

As for vaginal candidiasis and if required add
Clotrimazole 1% cream applied to anogenital area 2-3 times per day

Or
Clotrimazole 10% vaginal cream insert 5g into the vagina once at night; dose may be repeated if necessary

NOTE: Clotrimazole creams damage latex condoms and diaphragms

Recurrence is likely if there are predisposing factors (eg, antibiotics, pregnancy, etc). Reservoirs of infection (e.g. at other skin sites, the gut, bladder, or in partners) may also lead to recontamination and should be treated
4. Menstrual disorders

Menstrual disorders include:

i) Menorrhagia
ii) Irregular menstruation
iii) Endometriosis
iv) Postponement of menstruation
v) Dysmenorrhoea

i) Menorrhagia

When treating menorrhagia, progestogens are only used to stop acute bleeding. Further treatment with tranexamic acid and a non-steroidal anti-inflammatory drug (NSAID) may be required.

To stop acute bleeding

**Norethisterone** 5mg, orally, three times a day for 10 days

For long-term control, if contraception required

First choice

**Combined oral contraceptive**, orally, daily (for choice of COC, see [Contraceptive Guidelines — Female, NHS Wirral](#))

Second choice

**Progesterone intra-uterine system** (Mirena®)

For long-term control, if contraception NOT required

First choice

**Tranexamic acid** 1,000mg, orally, three times a day for up to four days after period has begun

Second choice

**Mefenamic acid** 500mg, orally, three times a day during period

Third choice

**Ibuprofen** 400mg, orally, three times a day

Or

**Naproxen** 250mg, orally, three to four times a day

**NOTE:** Before prescribing an NSAID, consider whether the patient has any cardiovascular or gastrointestinal risk factors. NSAIDs should be prescribed at the lowest effective dose and for the shortest possible duration

ii) Irregular menstruation

If contraceptive required

**Combined oral contraceptive (COC)**, orally, daily (for choice of COC, see [Contraceptive Guidelines — Female, NHS Wirral](#))

If contraception NOT required
**Norethisterone** 5mg, orally, daily; take from day 5 to day 26 of menstrual cycle for 3-4 cycles.

### iii) Endometriosis

Where endometriosis requires drug treatment, it may respond to a progestogen administered on a continuous basis. For severe endometriosis progestogens and dydrogesterone can be given alone, in a cyclical basis or in conjunction with an oestrogen.

If contraceptive required

**Combined oral contraceptive**, orally, daily (for choice of COC, see [Contraceptive Guidelines — Female, NHS Wirral](#)).

If contraception NOT required

**First choice**

**Norethisterone** 10mg, orally, daily for 4 to 6 months; start on day 5 of menstrual cycle; increase dose to 20 to 25mg daily (in divided doses) if spotting occurs then reduce once bleeding has stopped.

**Second choice**

**Dydrogesterone** 10mg, orally, two or three times a day; take continuously.

### iv) Postponement of Menstruation

**Norethisterone** 5mg, orally, three times a day. Start 3 days before anticipated onset of period. Menstruation will occur 48 hours after treatment finishes.

**Or**

**Medroxyprogesterone** 10mg, orally, daily for 7–10 days.

### v) Dysmenhorroea

If contraceptive required

**Combined oral contraceptive**, orally, daily (for choice of COC, see [Contraceptive Guidelines — Female, NHS Wirral](#)).

If contraception NOT required

**First choice**

**Ibuprofen** 400mg, orally, three times a day

**Or**

**Naproxen** 250mg, orally, three to four times a day

**Second choice**

**Dydrogesterone** 10mg, orally, twice a day; take from day 5 to day 26 of menstrual cycle.
5. Menopause

This section is under development.

6. Vaginal atrophy due to oestrogen deficiency

First choice
Vagifem® vaginal tablets Insert 1 tablet (10 micrograms), vaginally, daily for 2 weeks. Then reduce to 1 tablet twice weekly. Review patient for continued need after 3 months.

Second choice
Gynest® (estradiol 0.01%) cream Insert 1 applicatorful, vaginally, daily for 2 weeks then reduce to 1 applicatorful twice weekly. Review patient for continued need after 3 months.

7. Contraception

For advice on selecting the most appropriate contraceptive treatment for a patient, see Contraceptive Guidelines — Female, NHS Wirral.

8. Hyperemesis

This is managed in 2 settings:
  i) Outpatient management
  ii) Inpatient management

See Wirral Women and Children’s Hospital Guideline 23 Hyperemesis Gravidarum for advice on the most appropriate management setting investigations, monitoring, treatment and management of this condition.

i) Outpatient management:

If ketonuria < 1
Cyclizine 50mg, orally, three times daily.

If ketonuria >1
Cyclizine 50mg, by IV or IM injection, stat and then 50mg, orally, three times daily.

Rehydrate with
Sodium chloride 0.9% 1 litre, by IV infusion, over 1 hour; then 1 litre, by IV infusion, over 2 hours.
Or
**Hartmann’s solution** 1 litre, by IV infusion, over 1 hour; then 1 litre, by IV infusion, over 2 hours.

**NOTE:** Double strength sodium chloride or glucose solutions must NOT be used.

If this is a repeated admission for rehydration

**Thiamine** 25mg, orally, three times daily

**ii) Inpatient management**

For inpatients tolerating oral medicines

**Step 1**

**Cyclizine** 50mg, orally, three times daily

**Step 2** — add

**Promethazine** 25mg, orally, three times daily

**Step 3** — add

**Metoclopramide** 10mg, orally, three times daily

**Step 4** — add

**Prochlorperazine** 10mg, orally, three times daily

For patients unable to tolerate oral medicines

**Step 1**

**Cyclizine** 50mg, by IV or IM injection, three times daily

**Step 2** — add

**Prochlorperazine** 12.5mg, by IM injection, three times daily

**Step 3** — add

**Metoclopramide** 10mg, by slow IV or IM injection, three times daily

Aim to switch back to oral treatment as soon as patient is able to tolerate.

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**9. Assisted Reproduction**

This section is under development.