GP Educational Evening
12th February

Matthew Long MD FRCOG

Matthew Long

- Qualified 1983
- MRCOG 1988 / FRCOG 1990
- Appointed Consultant 1993
- MD (University of London) 1995
- RCOG preceptor for advanced MAS

Matthew Long - main interests

- Pelvic organ Prolapse and incontinence
- Heavy menstrual bleeding / fibroids / endometriosis
- Menopause, HRT including female testosetreone replacement therapy

Themes

- Menopause
- Urinary urgency
- Prolapse

Case 1

- 55 years old
- Menopause aged 52
- Menopausal Sx
- Estradiol improves Sx
- Progestogenic S/E with oral progestogens
- Superficial dyspareunia despite oral estradiol
- Reduced energy / libido
- Gritty eyes/ soreness

Progesterone effect on endometrium

- Cyclical progestogens with HRT induce withdrawal bleed
- Hyperplasia rate approx 6% (Sturdee)
- Continuous progestogens < 1% hyperplasia
- Recommendation to change women form cyclical HRT to CCHRT after 5 years
- Erratic bleeding initially due to secretory effect then settles when inactive

Mirena and ERT

- Endometrial anti proliferative effect prevents estradiol stimulation and hyperplasia
- License for 4 yrs use
- No need for oral/systemic progestogen
- Route of estradiol delivery not relevant eg, oral, patch, gel or implant
- If previous erratic bleeding on HRT exclude other pathology

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Vaginal Oestrogens

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- Creams / Tablets / Rings
- Reduce urogenital Sx and possibly UTI's
- Can reduce irritative bladder symptoms
- NB -25% women on HRT urogenital atrophy
- long term use needed as atrophic Sx return

Long Term Vaginal Oestrogens

- Endometrial data - no significant risk with tablets or rings (local)
- No need for Progesterone challenge
- Breast Ca – minimal risk studies ongoing for women with a Hx of breast Ca
- Thrombotic data sparse but risk extremely small
- Conclusion – safe in longer term
- Vagifem 10 micrograms licensed for long term use

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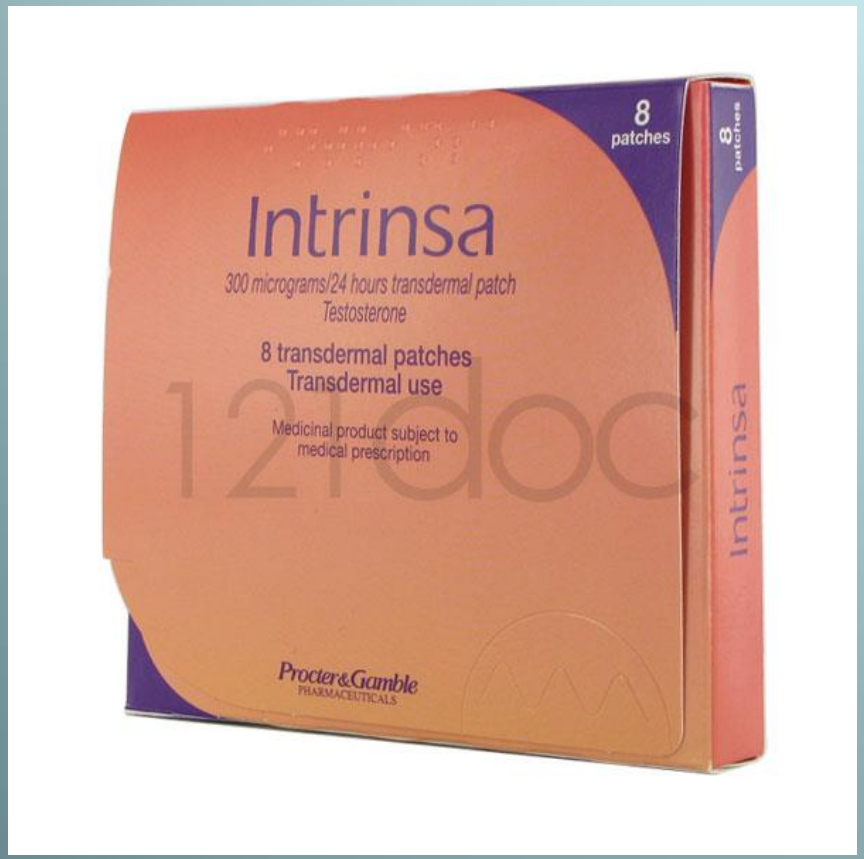
Testosterone

- Hypoactive Sexual Desire Disorder
- HSDD
- Some evidence testosterone improves libido
- Study in hysterectomised women also on ERT under age of 60
- Transdermal testosterone – 300mcg/24 h

Testosterone

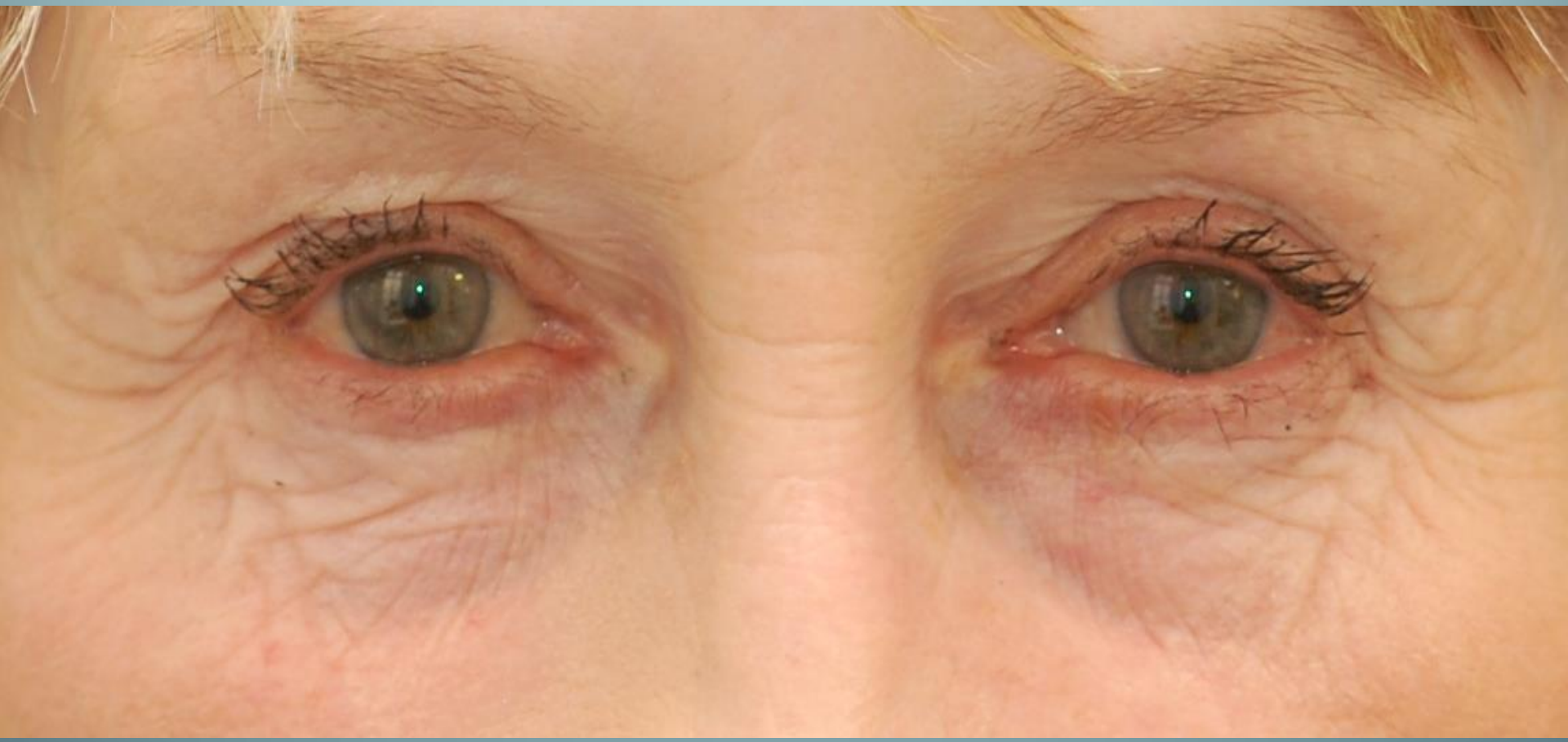


- Now not available

Testosterone

- Testogel or Testim gel
- Not licensed for use in women – UULP
- 1/16th sachet daily initially
- Counsel about S/E and use in women
- Testosterone levels after 3 weeks and then adjust dose

Dry Eye Syndrome



Dry Eye Syndrome

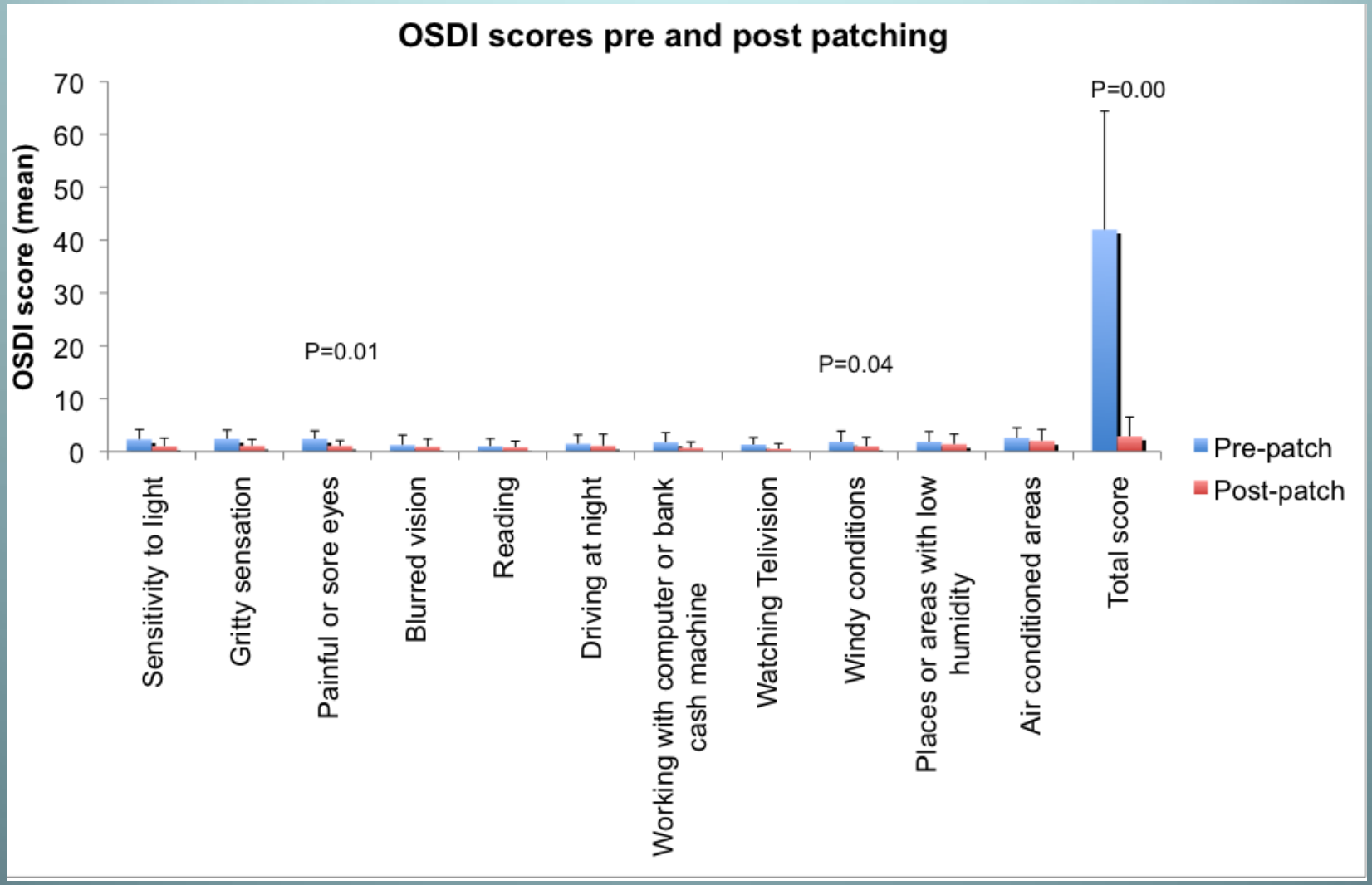
Dry Eye Syndrome

- Warm eye compresses
- Flax seed
- Artificial tears
- Ophthalmology intervention – eg. punctal duct plugs

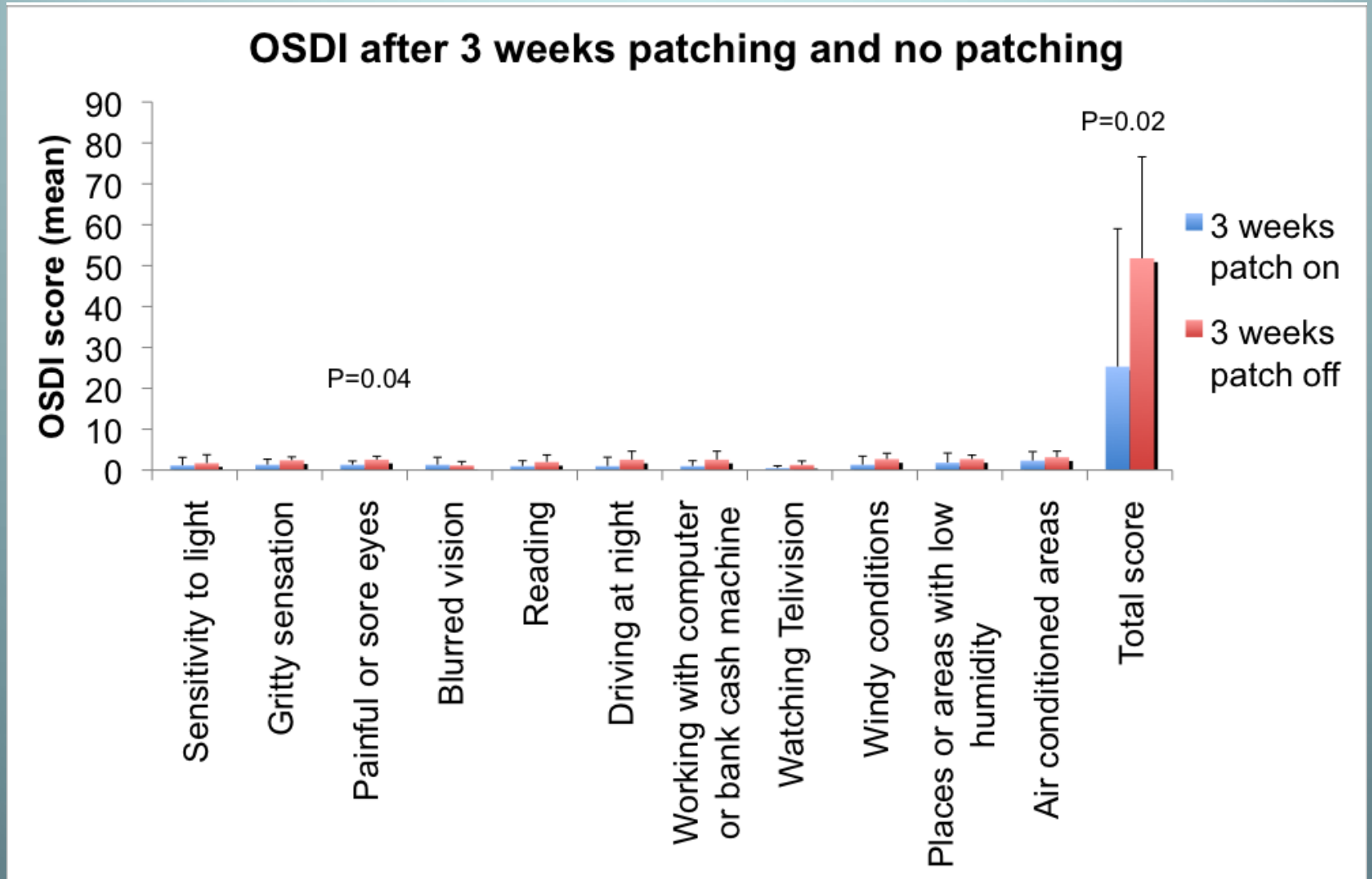
Testosterone
Dry Eye Syndrome

- Some evidence low testosterone levels associated
- USA small study shown improvement with testosterone
- Idiopathic or Sjogren's syndrome reduce activity of meibomian glands

Female Testosterone therapy and dry eyes



Female Testosterone therapy and dry eyes




MALDIVIAN AIR TAXI
8Q-MAT

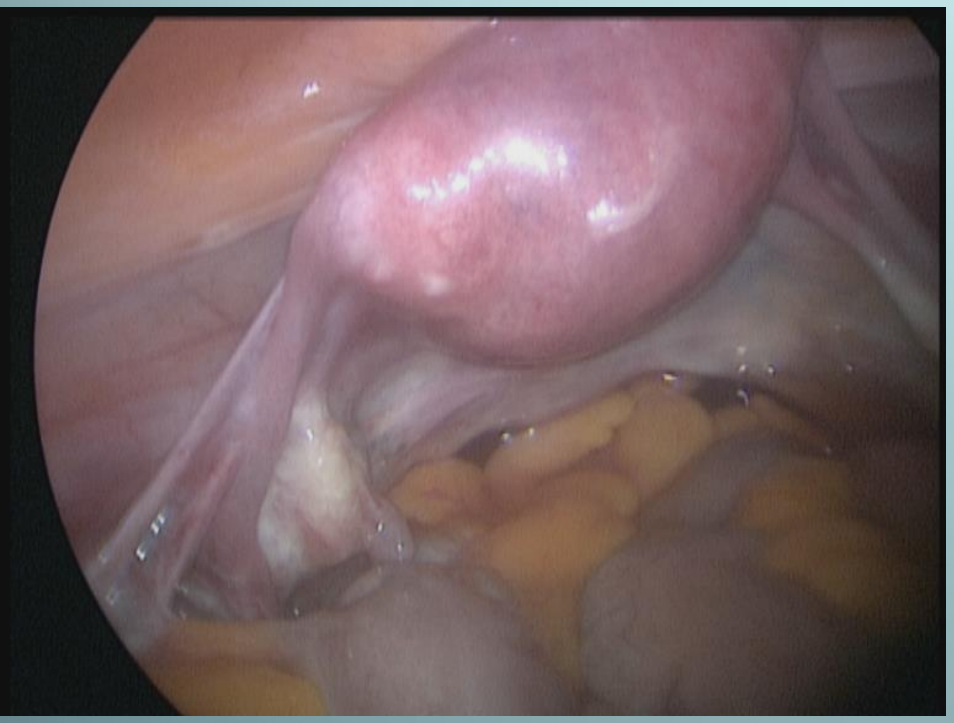
Case 2

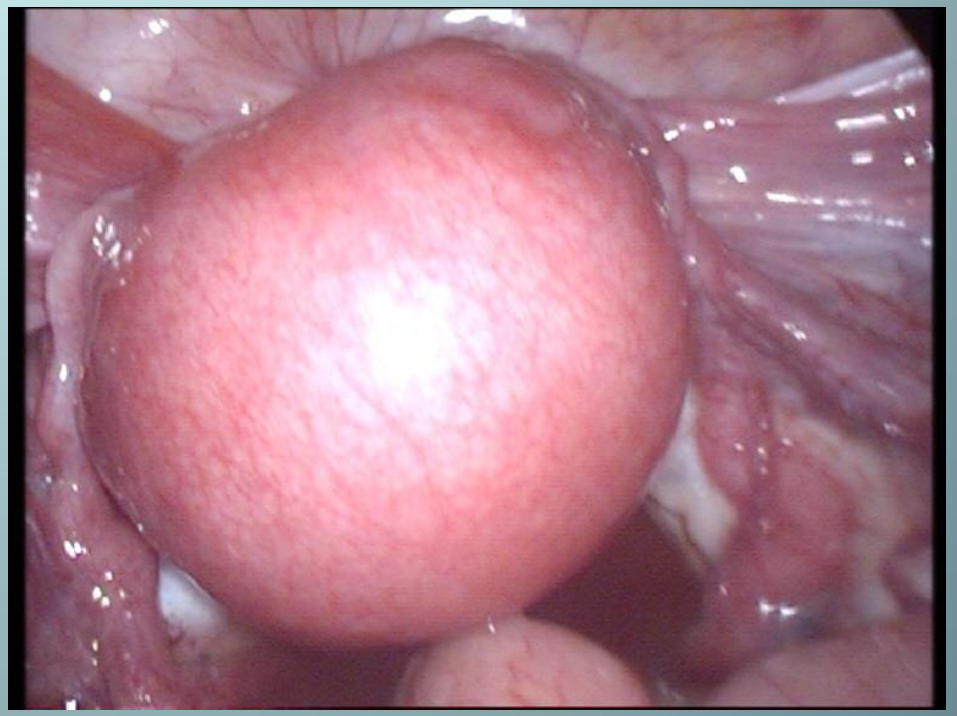
- Urinary frequency
- Urgency, occ urge incontinence
- Nocturia 2-3x
- No USI

Exclude

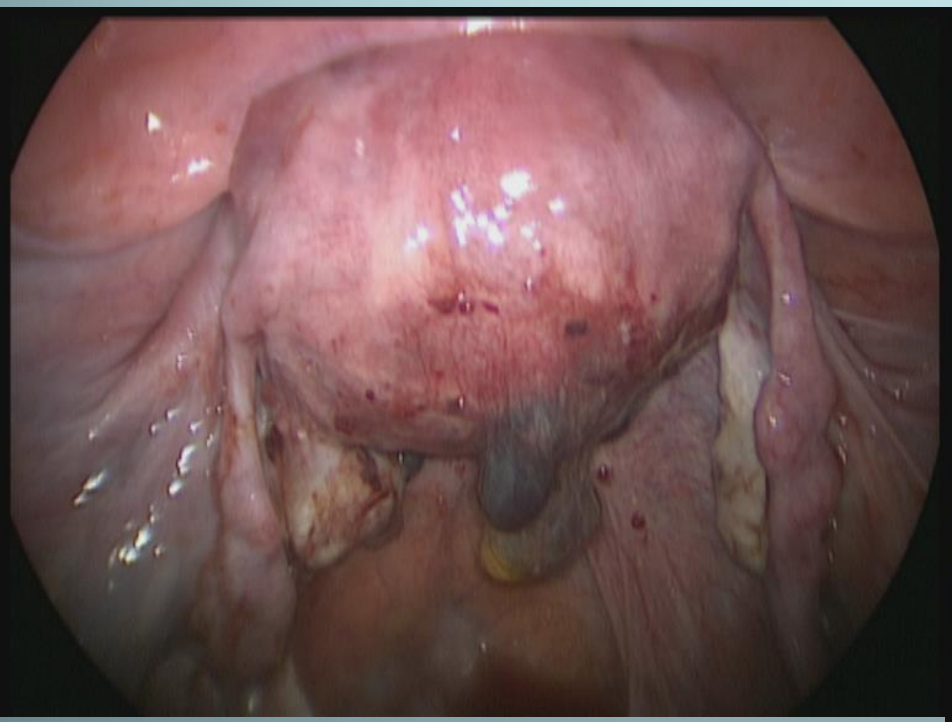
- UTI
- Diabetes
- Voiding disorders
- Pelvic masses
- Utero-vaginal prolapse

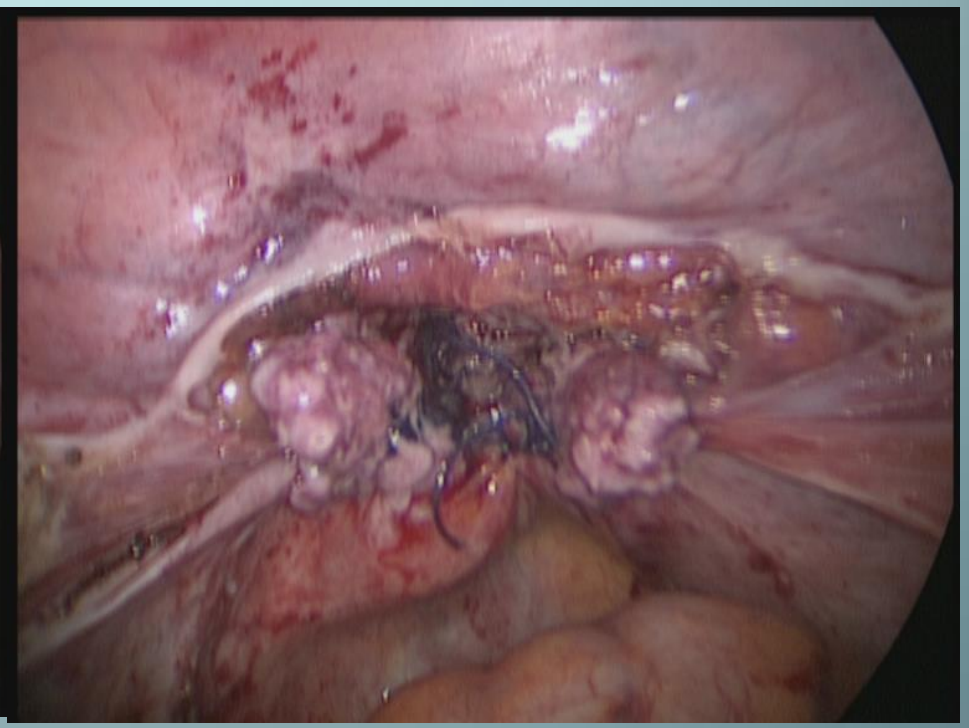
Fibroids



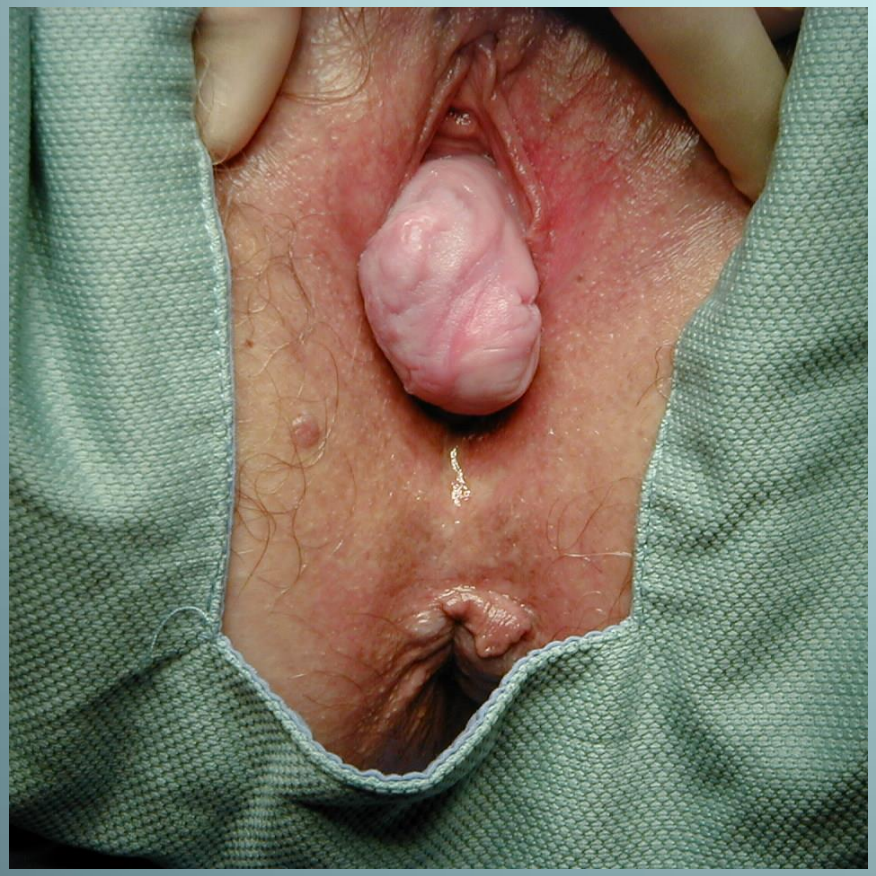


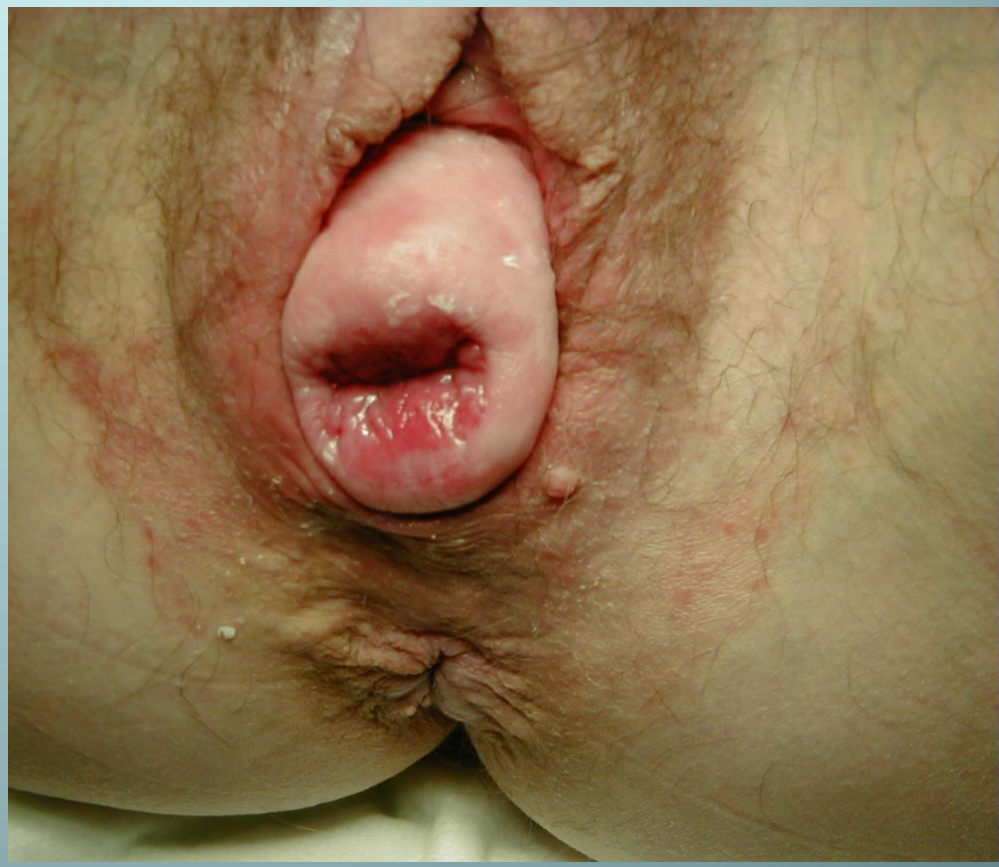
Minimal Access Hysterectomy





Prolapse





Pessaries

- Ring pessary – cystocoele/vault
- Shelf pessary – vault + high cystocoele
- Gelhorn – vault + high cystocoele
- Hodge pessary used for anteverting a retroverted uterus – rarely now
- NB Pessaries do not control enterocoele/rectocoele well

Overactive Bladder

- Urinary leakage due to an unprovoked detrusor contraction
- Detrusor hyper reflexia - above due to neurological problems eg. MS, cord injury, prolapsed IVD

OAB Therapies

	Success	Relapse
Bladder Drill	70%	40%
Biofeedback	80%	50%
Hypnosis	86%	40%
Acupuncture	87%	?

OAB - Therapies

- Dietary/Fluid intake
- Weight loss if BMI > 30
- Behavioural - Bladder drill – minimum 6 weeks
- Physiotherapy
- Biofeedback
- Complimentary - acupuncture/hypnosis

OAB - Mainly antimuscarinic

- Oxybutynine – 1st line
- Tolterodine – 1st line
- Darifenacin – 1st line
- Solifenacin
- Trospium
- Propiverine
- (DDAVP – Desmopressin – special circumstances)
- Vaginal Estrogen

Side Effects

- Dry mouth
- Constipation
- Dyspepsia/reflux
- Dry eyes/blurred vision
- Difficulty sleeping
- Urinary retention
- NB narrow angle glaucoma

Preparations

- Long acting agents
- Oxybutynine/Tolterodine
- Transdermal – Oxybutynin
- Reduced CNS absorption
- Trospium

- Vagifem

Success

Generally same for most drugs

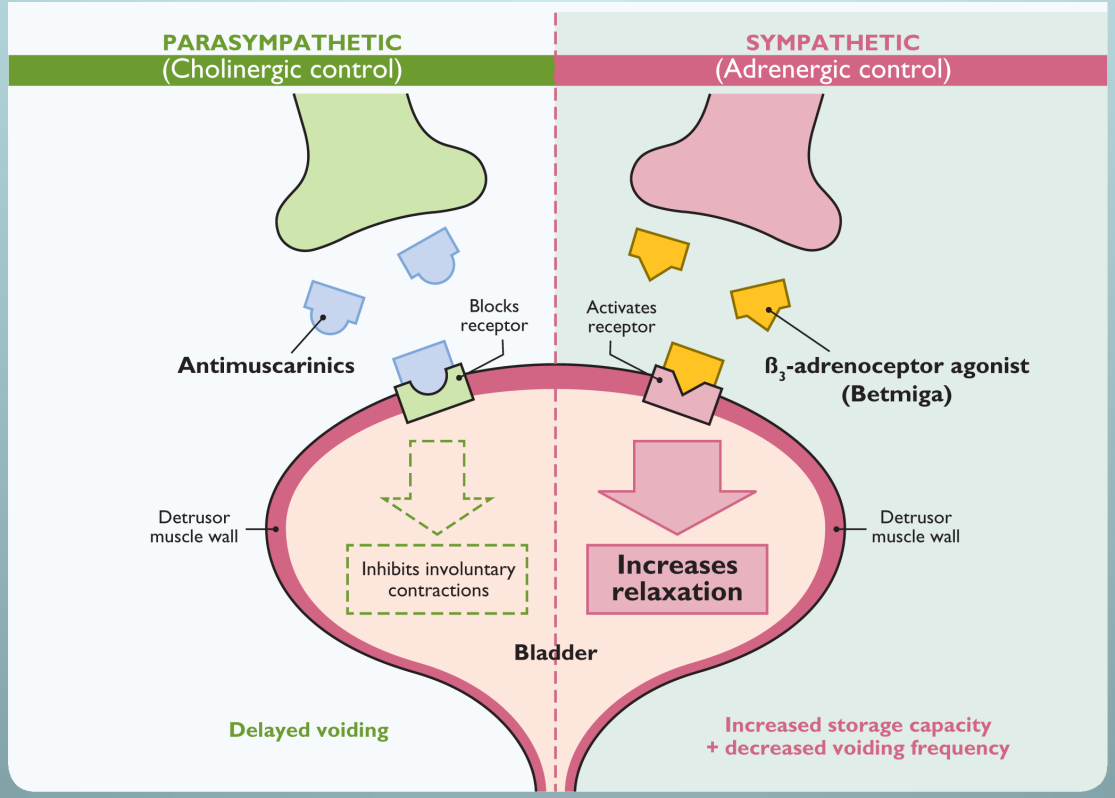
- 80 % patients improve
- 40 - 60% reduction in symptoms
- Do not offer generic oxybutynin to frail or elderly women
- Offer telephone or face-face consultation 4 weeks after starting drug therapy
- 6 month to annual review

Vaginal Oestrogens

- Creams / Tablets / Rings
- Reduce urogenital Sx and possibly UTI's
- Can reduce irritative bladder symptoms
- NB -25% women on HRT urogenital atrophy
- long term use needed as atrophic Sx return
- Offer to post-menopausal women – NICE 2013

Mirabegron

Mode of action of OAB treatments[1,3]



Adapted from Betmiga Summary of Product Characteristics, December 2012[1] and Chu *et al.*, 2006.[3]

1. Betmiga Summary of Product Characteristics, December 2012.
2. Gras J. *Drugs of Today* 2012;**48**(1):25-32.
3. Chu F, Dmochowski R. *Am J Med* 2006;**119**(3A):3S–8S.

Date of preparation: February 2013. BET13018UK

Mirabegron

- Beta – 3 adrenoreceptor agonist
- Reduces activity detrusor muscle
- 50mg dose once daily
- If renal/hepatic impairment then 25mg once daily
- Avoids anticholinergic S/E
- Can cause palpitations
- Abnormal cardiac rhythm uncommon

Mirabegron

- Can take 2-3 weeks to have an effect
- Alternative to anti- cholinergic agents especially if S/E, intolerance or ineffectual
- Can be used in addition to anti-cholinergic agent
- Average cost - £27 per 28 days
- Generic oxybutynin £6.11 per 56 days (NB S/E)
- Nice guidance – use as second line drug

OAB only - What to do

- If normal voiding :-
- General therapies
- +/- drug therapy
- +/- vaginal E2

- If abnormal voiding/ Failed treatment
- Refer - urodynamic studies/cystoscopy

Urinary Incontinence – Overactive Bladder

- 1st published 2006 CG 40
- Now replaced by CG 171
- Published September 2013
- 116 recommendations – covers primary care and secondary care
- NICE Pathway 2013

NICE Summary

- Decide type of incontinence – mixed picture treat predominant symptom
- Precipitating factors
- Pelvic masses
- Pelvic floor contraction strength
- Urine dip
- Screen for voiding dysfunction
- Urinary diaries – minimum 3 days

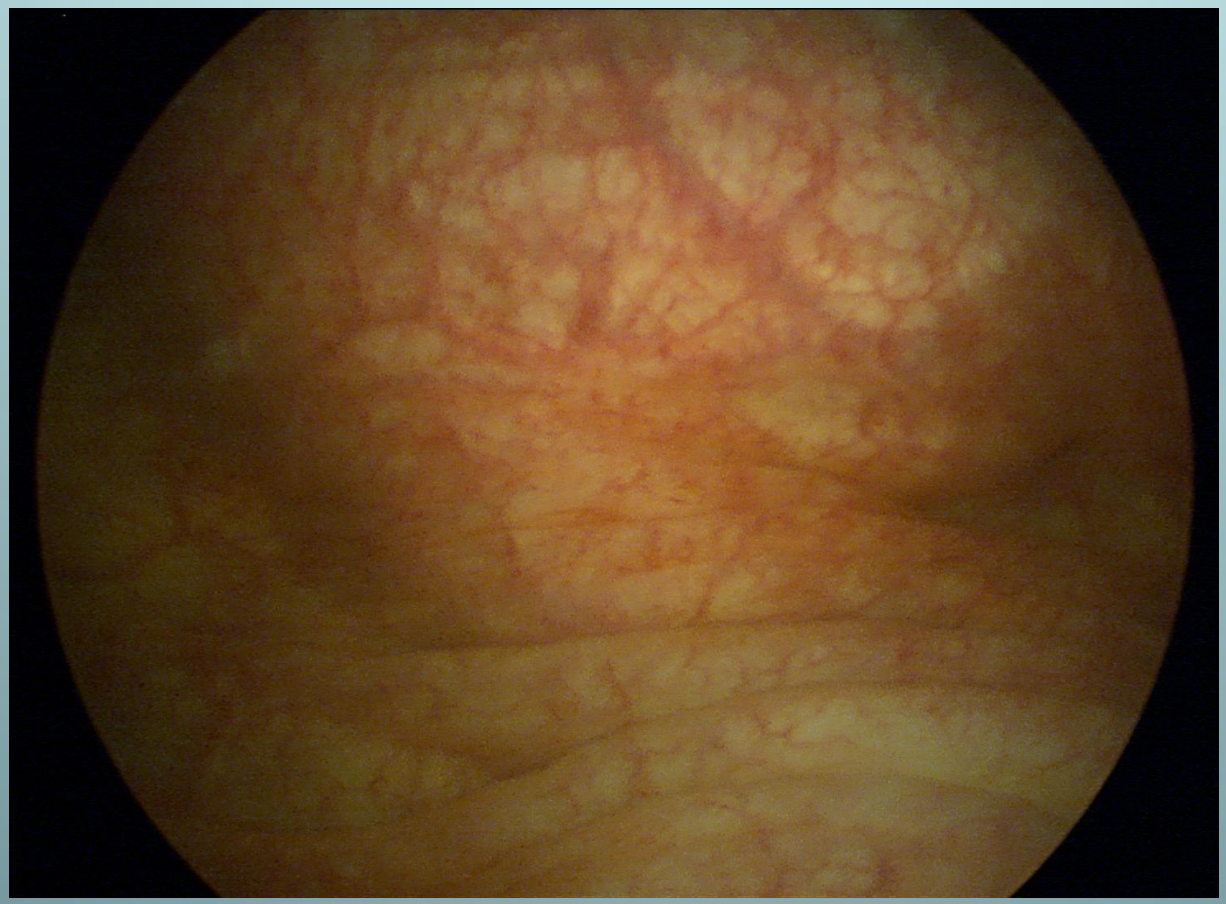
Pelvic Floor Contraction Strength

- Assess digitally - Oxford Scoring System
  - 0 = no contraction
  - 1 = flicker
  - 2 = weak
  - 3 = moderate
  - 4 = good
  - 5 = strong
- If prolapse seen reaching introitus refer onto specialist

UI Referral Criteria

- Haematuria
- Suspicion of neoplasia
- Bladder pain
- Voiding disorder
- Benign pelvic mass
- Failed conservative therapy

Painful bladder syndrome



UI Referral Criteria

- Previous continence or prolapse surgery
- Significant prolapse - visible at introitus
- Previous cancer therapy
- Possible urogenital fistula
- Associated faecal incontinence
- Possible neurological disease

Other Therapies

- Do not offer Transcutaneous Posterior Tibial Nerve Stimulation
- Do not offer Percutaneous Posterior Tibial Nerve Stimulation routinely - only after specialist review when other therapies have failed
- Do not offer Transcutaneous Sacral Nerve Stimulation routinely – only after specialist review when other therapies have failed

Surgical Therapies

- Only after conservative and medical therapy has failed
- Botulinum A therapy after failure of medical therapy and patient able to perform CISC
- Augmentation cystoplasty – decreasing use
- Urinary diversion – rare
- Sacral Nerve Stimulation -rare

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Q & A’s