7: Obstetrics, gynaecology and urinary–tract disorders

Table of contents:

7.2 Treatment of vaginal and vulval conditions

7.2.1 Preparations for vaginal and vulval changes

Estriol 0.1% cream (Ovestin®)	15g
Estradiol 10microgram vaginal tablet (Vagirux®)	24

Topical oestrogens should be used in the smallest effective amount to minimise absorption of the oestrogen. Risk of endometrial hyperplasia and carcinoma on long term or repeated use of topical vaginal oestrogens is uncertain; treatment should be reviewed at least annually with a special consideration given to any symptoms of endometrial hyperplasia or carcinoma.
Note – Estradiol 0.06% transdermal gel (Oestrogel Pump Pack®) is licenced only for transdermal hormone replacement therapy for oestrogen deficiency symptoms in postmenopausal women. It is not to be used locally for vaginal atrophy.

7.2.2 Vaginal and vulval infections

*** Refer to chapter 5 of the Sheffield Formulary for more detail ***

Preparations for vaginal and fungal candidiasis

Clotrimazole 500mg pessary	single dose
Fluconazole 150mg capsule	single dose
Clotrimazole 1% cream	20g, 50g

Candidal vulvitis can be treated locally with cream but is almost invariably associated with vaginal infection which should also be treated using pessaries or cream inserted high into the vagina. All topical and oral azoles give a 75% cure. Oral fluconazole treatment may be considered as second line for infections not responded to topical treatment or for situations where topical treatment cannot be used.
In pregnancy, avoid oral azoles and use clotrimazole 100mg pessaries for 6 nights.

Preparations for other vaginal infections

Metronidazole 0.75% vaginal gel	40g
Clindamycin 2% cream	40g

For bacterial vaginosis oral metronidazole should be considered as first line treatment. It is as effective as topical treatment but is cheaper.
See Chapter 5 for more detailed information and advice on use in pregnancy.

7.3 Contraceptives

NICE CG30 Long-acting reversible contraception, Oct 2005 last updated July 2019

- Individuals requiring contraception should be given information about and offered a choice of all methods, including LARC methods.
  (**Which method of contraception is right for me? | Sexwise**)
- Individuals should be provided with the method of contraception that is most acceptable to them, unless it is contraindicated. Those considering LARC methods should receive detailed information- both verbal and written- to enable them to choose a method and use it effectively.
- Increasing the uptake of LARC methods may help reduce the numbers of unintended pregnancies.

Detailed guidance on contraceptives is available from the Faculty of Sexual and Reproductive Healthcare (FSRH), including:

UK Medical Eligibility Criteria (UKMEC) for contraception use
Guidelines and statements
Drug Interactions with hormonal contraceptives

7.3.1 Combined hormonal contraceptives (CHCs)

See Appendix 2 for combined oral contraceptive (COC) guidelines.
Patient information leaflet on COCs is available here

Combined oral contraceptives (COCs) Branded generic versions of most COCs are available that offer cost savings over the originator brands Preferred brands are indicated in **bold**.				
Type of Preparation	**Oestrogen content**	**Progestogen content**	**Sheffield First Line**	**Second Line**
Low strength 21-day preparations	Ethinylestradiol 20micrograms	Desogestrel 150micrograms	**Gedarel® 20/150**	Bimizza® 150/20
		Gestodene 75micrograms	**Millinette® 20/75**	Akizza® 75/20
24 active and 4 placebo tablets		Drospirenone 3mg (see note below*)	**Eloine®**	No second choice
Standard strength 21-day preparations	Ethinylestradiol 30micrograms	Levonorgestrel 150micrograms	**Rigevidon®**	Levest® 150/30
		Desogestrel 150micrograms	**Gedarel® 30/150**	Cimizt® 30/150
		Gestodene 75micrograms	**Millinette® 30/75**	Femodene®
		Drospirenone 3mg (see note below*)	**Yacella®**	Dretine®
	Ethinylestradiol 35micrograms	Norgestimate 250micrograms	**Lizinna®**	Cilique®
Multiphasic 21 day preparations	Ethinylestradiol 30 micrograms	Levonorgestrel 50 micrograms	TriRegol®	Logynon®

COCs should be prescribed by brand.

*Drospirenone has antiandrogenic properties and diuretic properties. These products are more expensive than other COCs and should not routinely be a first or second choice. They may be preferred for individuals with acne, cyclical weight gain or premenstrual dysphoric disorder, taking into account the thromboembolic risk. Use with care if an increase in plasma potassium concentration might be hazardous

Risk of venous thromboembolism with desogestrel or gestodene containing pills is approximately 9-12 per 10,000 individuals per year of use compared with 5-7 per 10,000 for individuals using pills containing levonorgestrel, norgestimate and norethisterone. The risk for drospirenone containing pills is similar to those containing desogestrel or gestodene.

https://www.gov.uk/drug-safety-update/combined-hormonal-contraceptives-and-venous-thromboembolism-review-confirms-risk-is-small
https://www.gov.uk/drug-safety-update/yasmin-risk-of-venous-thromboembolism-higher-than-levonorgestrel-containing-pills

MHRA conclude that:

- the risk of blood clots with all low dose (≤50micrograms ethinylestradiol) combined hormonal contraceptives (CHCs) is small.
- there is good evidence that the risk of venous thromboembolism (VTE) may vary between products, depending on the progestogen.
- CHCs that contain levonorgestrel, norethisterone, or norgestimate have the lowest risk of VTE.
- the benefits of any CHC far outweigh the risk of serious side effects.
- prescribers and individuals should be aware of the major risk factors for thromboembolism, and of the key signs and symptoms.

Provided individuals are informed of the relative risks of venous thromboembolism and accept them, the choice of oral contraceptive is for the individuals to make jointly with the prescriber in light of their individual medical history, contra-indications and experience with other contraceptive formulations. Risk factors should be reassessed at routine appointments.

7.3.2 Progestogen-only contraceptives (POCs)

7.3.2.1 Oral progestogen-only contraceptives (POPs)

Patient information leaflet on POPs is available here

Note: These should be **prescribed generically**

Desogestrel 75micrograms	**3 x 28**
Norethisterone 350micrograms	3 x 28
Levonorgestrel 30micrograms	1 x 35

Desogestrel has not demonstrated a better contraceptive rate over traditional POPs but is the first line formulary choice as it has a 12 hour window compared with the 3 hour window for traditional POPs; generic prescribing is recommended to maximise cost effectiveness.
Drospirenone 4mg (Slynd®) is a new POP with a 24 hour window and a 4 day pill free interval to improve bleeding pattern. It is more expensive than desogestrel and it is only advised for selected individuals where the wider window or bleeding pattern offers an advantage. Note – the missed dose advice differs from the other POPs and caution in users at risk of hyperkalaemia.
https://www.fsrh.org/news/fsrh-ceu-statement-drospirenone-4mg-progestogen-only-pill-slynd/

7.3.2.2 Parenteral progestogen-only contraceptives

Injectable preparations

Patient information leaflet on injectable progestogens is available here

Medroxyprogesterone acetate 150mg/ml IM- DMPA (Depo-Provera®)	1ml
Medroxyprogesterone acetate 104mg/0.65ml SC-DMPA (Sayana Press)	0.65ml

Sayana Press is suitable for self-administration, following suitable training by a health care professional (refer to SPC).

DMPA injections require to be disposed in a purple sharps container (See SPS guidance). Ensure this is prescribed for patients who are self-administering Sayana Press.

The use of progestogen-only injectable is associated with a small loss of BMD; this is usually recovered after stopping the injection and there is no evidence that the progestogen-only injectable increases the risk of fracture. Bone density scanning should be considered at initiation of treatment only for individuals at higher risk of bone loss and after 5 years in those using it as a long-term method of contraception. See Appendix 1 for further information.

Implants** **(Subdermal)**

Patient information leaflet on progestogen implant is available here

Etonogestrel 68mg in radiopaque flexible rod (Nexplanon®)

There have been rare reports of neurovascular injury and implant migration from the insertion site, including into the pulmonary artery. For further information and recommendations for healthcare professional see MHRA Drug Safety Update alerts:

https://www.gov.uk/drug-safety-update/nexplanon-etonogestrel-contraceptive-implants-reports-of-device-in-vasculature-and-lung (June 2016)

Nexplanon (etonogestrel) contraceptive implants: new insertion site to reduce rare risk of neurovascular injury and implant migration (Feb 2020)

7.3.2.3 Intra-uterine progestogen-only system** #
Patient information leaflet on progestogen intra-uterine system (IUS) is available here

Mirena® - levonorgestrel 52mg (20micrograms/24 hours)
Levosert® Levonorgestrel 52mg (20micrograms/24 hours)

Refer to Chapter 6 Endocrine, section 6.4.1.2 for information on use for protection from endometrial hyperplasia during oestrogen replacement therapy

Levonorgestrel-releasing intra-uterine systems (LNG-IUS) should always be prescribed by brand name because products have different indications, durations of use, and introducers (MHRA DSU Jan 2016) . Note: consult product SPCs for up-to-date information on licensed indications and duration of use.

For further information and comparison of available LNG-IUS products see:
FSRH Guidance Intrauterine Contraception (Mar 23, amended July 23) and
CEU statement Mirena: extension of licence for contraception to 8 years (Jan 24)

7.3.4 Intra-uterine contraceptive devices (IUDs) **
Patient information leaflet on IUDs is available here

****IUDs, IUS and implants should only be inserted by those who are trained and regularly fitting.**

7.3.5 Emergency contraception (EC)
Patient information leaflet on emergency contraception is available here

Ulipristal acetate 30mg tablet 1 dose
Note: Ulipristal 5mg tablet (BNF 6.4.1.2) is the preparation used for fibroids not EC.

Levonorgestrel 1.5mg tablet 1 dose
Note: **do not prescribe as OTC brands** e.g. Levonelle® One Step as they are more expensive.

Notes:

1. A copper IUD (Cu-IUD) is the most effective method of EC and should be considered by ALL individuals who have had unprotected sexual intercourse (UPSI) and do not want to conceive.
   - Individuals should be given information regarding all methods of EC and signposted to services that can provide them. If an individual is referred on for a Cu-IUD, oral EC should be given at the time of referral in case the Cu-IUD cannot be inserted, or the individuals changes their mind. FSRH Guidance - Emergency Contraception (March 2017 amended July 2023)
   - To refer a patient for a Cu-IUD contact Sexual Health Sheffield

2. Choice between ulipristal (UPA) and levonorgestrel (LNG) should be individualised based on cost-effectiveness. Consider UPA as first line if UPSI is likely to have taken place during the 5 days prior to the estimated day of ovulation, or if UPSI occurred 96-120 hours ago.
   It is important to bear in mind that the evidence suggests that both drugs are ineffective if taken after ovulation.

3. Additional factors to consider when choosing between oral EC include:
   - interaction with any recently taken progestogen-containing drugs
   - interaction with enzyme inducing drugs
   - BMI/body weight
   - requirement for ongoing contraception.

For more information see FSRH EC algorithm 2 - Decision-making Algorithm for Oral Emergency Contraception (page x)

7.4 Drugs for genito-urinary disorders

7.4.1 Drugs for urinary retention

Alpha-blocker for treatment of benign prostatic hyperplasia (BPH):

Tamsulosin 400micrograms modified release capsules

Alpha-blockers - note: drowsiness or dizziness may affect performance of skilled tasks (e.g. driving); effects of alcohol may be enhanced; risk of postural hypotension (contraindicated in history of PH); if patient receiving antihypertensives these should be reviewed when starting an alpha-blocker for BPH - may require reduced dosage and specialist supervision

Alpha-blocker ineffective or prostate significantly enlarged:

Finasteride 5mg tablets (see chapter 6 section 6.4.2 antiandrogens)

Combination of finasteride and tamsulosin

After initiating finasteride treatment, improvement may be seen within a short time, but the full effect may not be achieved until 6 months of treatment.
Condoms should be worn if partner is pregnant or could become pregnant and these individuals should avoid handling crushed/broken finasteride tablets because of the possibility of absorption and risk to a male foetus.
Finasteride decreases serum concentration of prostate cancer markers such as prostate-specific antigen; reference values may need adjustment. See SPC for more details.
MHRA Drug Safety Update (2024): Finasteride: reminder of the risk of psychiatric side effects and of sexual side- effects, which may persist after discontinuation of treatment. Healthcare professionals are reminded to monitor patients for both psychiatric and sexual side-effects.

Tadalafil 5mg (section 7.4.5)

Tadalafil 5mg (once daily) is licensed for the management of BPH. Use in men with moderate-to-severe symptoms with or without erectile dysfunction, where alpha blockers or finasteride are ineffective or unsuitable or as an adjunct to maximum medical therapy before referral for surgery. Note, for indications other than erectile dysfunction the SLS criteria do not apply.

7.4.2 Drugs for urinary frequency, enuresis and incontinence

Lifestyle and physical therapies should be considered before drug treatments

For further information, please refer to the following NICE guidance:
NG123 Urinary Incontinence and pelvic organ prolapse in women (2019)
CG97 Lower urinary tract symptoms: the management of lower urinary tract symptoms in men. (2010 last updated 2015)
NG210 Pelvic floor dysfunction: prevention and non-surgical management (2021)
CG111 Bedwetting in under 19s (2010).

TA999 Vibegron for treating symptoms of overactive bladder syndrome (2024)
TA290 Mirabegron for treating symptoms of overactive bladder (2013)

Local pathway:
Adult continence clinical pathway (August 2023)

Appendix 3 Medication Pathway for Treatment of Overactive Bladder (Adults)

Anticholinergics (Antimuscarinics)

Solifenacin succinate 5mg, 10mg tablets
Oxybutynin hydrochloride immediate release 2.5mg, 5mg tablets*

* Caution in elderly people. NICE NG123 advises: Do not offer oxybutynin immediate release to older women who may be at higher risk of sudden deterioration in their physical or mental health.

Tolterodine tartrate 1mg, 2mg tablets **or** where once daily dosing is required
Tolthen XL® (tolterodine tartrate) 2mg, 4mg MR capsules
Trospium chloride 60mg MR capsules**

** Trospium MR does not cross the normal blood-brain barrier in significant amounts and may be a first line option for elderly patients and those at risk of CNS side-effects.

Beta-3 adrenoceptor agonist

Mirabegron 25mg, 50mg MR tablets ***
Vibegron ▼ 75mg tablets

See Appendix 3 supporting information for place in therapy.

*** **Note:** Mirabegron is contraindicated in patients with severe uncontrolled hypertension (systolic blood pressure ≥180 mm Hg or diastolic blood pressure ≥110 mm Hg, or both). See MHRA warning for more information. Monitor BP before starting treatment and regularly during treatment, especially in patients with hypertension.

Stress incontinence is generally managed by non-drug methods.

Duloxetine is licensed for the treatment of moderate to severe stress incontinence in women; NICE NG123 advises that it should not routinely be offered but may be considered as second line- therapy if women prefer pharmacological to surgical treatment or are not suitable for surgical treatment.

Intravaginal devices (Drug Tariff Part IXB Incontinence appliances): NICE NG210 (section 1.6.21) recommends to consider a trial of intravaginal devices for women with urinary incontinence, only if other non-surgical options have been unsuccessful. The Continence Advisory Service will advise on prescribing of these devices.

Ring pessaries (Drug Tariff Part IXA Appliances): NICE NG210 (section 1.6.22) recommends to consider pessaries for women who have symptomatic pelvic organ prolapse.

Primary nocturnal enuresis (children 5 years to adults up to 65 years)

Desmopressin tablets 200micrograms

Desmopressin sublingual tablets 120micrograms, 240micrograms
Desmopressin oral lyophilisate (sublingual) 120micrograms, 240micrograms (DesmoMelt®)
Desmopressin oral solution 360mcg/ml (Demovo®)

Idiopathic nocturnal polyuria in adults

Desmopressin oral lyophilisate (sublingual) 25micrograms, 50micrograms (Noqdirna®)

Limit fluid intake to minimum from 1 hour before dose until 8 hours afterwards.

Note the following dose equivalents when switching between desmopressin preparations: Desmopressin tablets 200micrograms is equivalent to 120micrograms sublingual or 180micrograms solution.

There is variation in the licensing of different medicines containing desmopressin see SPCs; desmopressin for diabetes insipidus (Chap 6 6.5.2) – specialist initiation.

7.4.5 Drugs for erectile dysfunction

Sildenafil 25mg, 50mg, 100mg tablets
Tadalafil 10mg, 20mg tablets
Tadalafil 5mg (once daily) tablets

Note: generic sildenafil has been removed from the selected list scheme (SLS). SLS endorsement is still required for Viagra® and other PDE-5 inhibitors.

Second line agents e.g. alprostadil preparations and Invicorp® (aviptadil 25 microgram/phentolamine mesilate 2mg) are initiated by specialist clinicians in secondary care. Following patient assessment and training in use of these preparations, prescribing is continued in primary care. For alprostadil, NHS prescribing for those who meet the SLS criteria otherwise as a private prescription.

Prescribing of vacuum pumps and constrictor rings: following assessment and training by the specialist clinician in secondary care, primary care will be requested to write the prescription for the supply of the pump. Subsequently, only on-going prescription of the constrictor rings is required by the primary care clinician.

Appendices:

Appendix 1 Effect of depo-medroxyprogesterone acetate [DMPA] on bone mineral density
Appendix 2 Combined oral contraceptive guidelines
Detailed guidance on contraceptives is available from the
Faculty of Sexual and Reproductive Healthcare Clinical Effectiveness Unit:
http://www.fsrh.org/pages/clinical_guidance.asp
Appendix 3 Medication Pathway for Treatment of Overactive Bladder (Adults)

Version control

8th Edition April 2025

Section 7.2: approved by APG April 2022; review April 2025
Section 7.3 Contraceptives and Appendix 1 and 2: updated and approved by APG April 2024; review date April 2027
Section 7.4 Drugs for genito-urinary disorders and Appendix 3 updated and approved by APG: April 2025; review date: April 2028.
Section 7.3.1 Combined Oral Contraceptive table and Appendix 2 updated as per IMOC approved Proposed Contraceptive Service Formulary. Updated and approved by APG chair July 2026.

Appendix 1:

The effect of depo-medroxyprogesterone acetate [DMPA] on bone mineral density

Individuals who use DMPA (Depo-Provera® / Sayana Press®) may lose significant bone mineral density (BMD). It is not yet known whether the effect on BMD increases the risk of osteoporosis and fractures in later life. There is some evidence that BMD starts to recover when DMPA is stopped but the extent of recovery is currently unknown and may be related to duration of exposure. The effect of DMPA may be more important in adolescents, in whom the usual process of bone mineral accretion may be reversed and the attainment on peak bone mass is not known, and in those approaching the menopause where additional BMD loss will occur.

The following is recommended:

- Individuals aged under 18 years, should not use DMPA first line for contraception because of its effect on BMD, but DMPA may be considered if all alternative contraceptive options are unsuitable or unacceptable.
- Individuals of any age with significant lifestyle and/or medical risk factors for osteoporosis, other methods of contraception should be considered prior to use of DMPA, which may be considered if all alternative contraceptive options are unsuitable or unacceptable. Significant risk factors for osteoporosis include:
  - Alcohol abuse and/or tobacco use
  - Chronic use of drugs that can reduce bone mass, e.g. anticonvulsants or corticosteroids
  - Low body mass index or eating disorder, e.g. anorexia nervosa or bulimia
  - Previous low trauma fracture or family history of osteoporosis
- In individuals of all ages, careful re-evaluation of the risks and benefits of treatment should be carried out every 2 years in those who wish to continue use.
- Individuals are generally advised to switch to another method at age 50 years. If they do not wish to stop DMPA, consideration may be given to continuation, providing the benefits and risks have been assessed and the individual informed of the potential risks.

References

FSRH Clinical Guideline: Progestogen-only injectable (Dec 2014, amended July 2023)
NICE CG30 Long acting reversible contraception (26 Oct 2005 last updated 2 July 2019)
MHRA Updated guidance on the use of Depo-Provera contraception (18 Nov 2004, available on National Archives here)
National Osteoporosis Guideline Group (NOGG) Clinical guideline for the prevention and treatment of osteoporosis (updated September 2021)

DMPA contraception and bone densitometry

The metabolic bone centre at STHFT has given the following advice on which individuals receiving DMPA should be referred for bone densitometry (Metabolic Bone Centre April 2014):

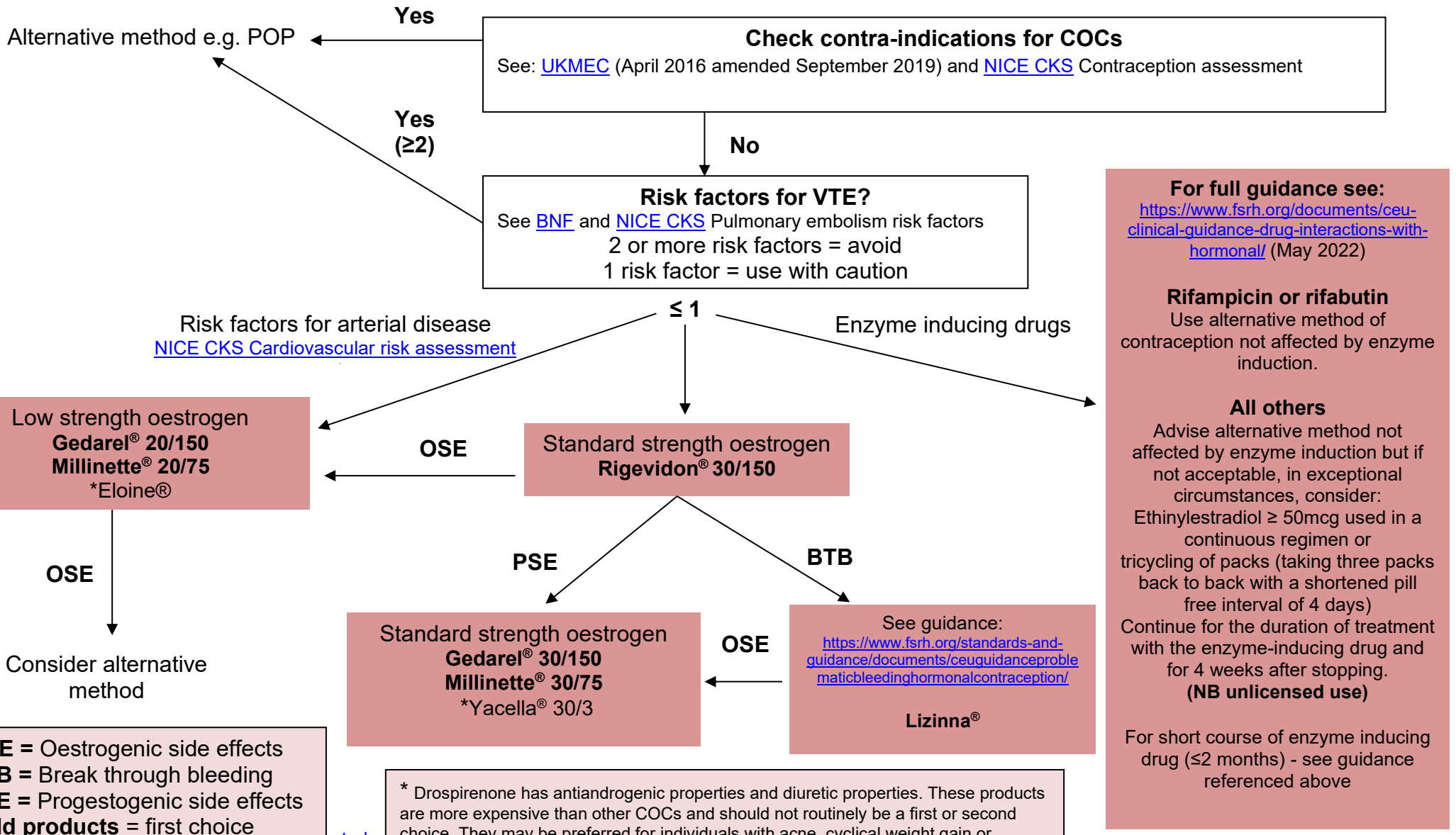
• Use of DMPA contraception is associated with a decrease in bone mineral density at the spine and hip. The majority of the bone loss occurs in the first few years. The bone loss is greater in individuals who use DMPA before peak bone mass (about age 25), and in smokers, individuals with low BMI, low dietary calcium intake or high alcohol intake. The decrease in BMD is mostly reversible on cessation of DMPA.
• Assessment of risk factors for low bone mass should be made when DMPA is being considered, particularly in young individuals. Lifestyle advice on maintaining bone density

should be given. In individuals at higher risk of bone loss, bone density measurement may be helpful when deciding whether to use DMPA. In individuals with no other risk factors for bone loss, bone density measurement is probably not required at initiation of DMPA.
• In individuals who wish to use DMPA long-term, a bone density measurement after five years may be helpful.

A more detailed guidance document is available from the Metabolic Bone Centre, Northern General Hospital, using the following link:
http://nww.sth.nhs.uk/STHcontDocs/STH_CGP/MetabolicBone/DepotGuideline.doc
For advice on individual cases the Metabolic Bone Centre doctors can be contacted on 0114 2714783.

Appendix 2

Combined Oral Contraceptive (COC) Guidance



Appendix 3

Medication Pathway for Treatment of Overactive Bladder (Adults)

This pathway is for adult patients who have failed conservative management for their overactive bladder symptoms. This includes trials of both lifestyle interventions and bladder training.

Is patient suitable for anticholinergic treatment?
See individual drug SmPCs for contraindications. Refer to the supporting information on the following page for information on prescribing and what constitutes treatment success/failure.

Yes

1st Line Anticholinergics

Initiate at the lowest recommended dose and titrate up if required. Review at 4 weeks

- **Solifenacin 5-10mg od**
- **Oxybutynin** immediate release 5mg bd-qds or 2.5mg in elderly. **Do not offer** to the frail elderly or to older women who may be at higher risk of a sudden deterioration in their physical or mental health.

If patient is at increased risk of CNS side-effects, consider trospium (see below)

Treatment failure or side-effects

Alternative Anticholinergics

Trial alternative 1st line drug (above) if appropriate or consider a 2nd line antimuscarinic. Review at 4 weeks.

Tolterodine immediate release 2mg bd (1mg if SEs troublesome)

Tolthen® XL 2mg, 4mg od (tolterodine MR) if once a day dosing is essential

Trospium XL 60mg od – Trospium MR does not cross the normal blood-brain barrier in significant amounts and may be a first line option for elderly patients and those at risk of CNS side-effects.

Treatment success

Treatment success

Continue treatment and review again at 12 weeks, then annually thereafter. More frequent review is required (every 6 months) if older than 75 years of age.

No

Is patient suitable for **beta-3 adrenoreceptor agonist**?
(mirabegron, vibegron▼)

Note: mirabegron contraindicated in uncontrolled hypertension (systolic ≥ 180mmHg and/or diastolic ≥110mmHg).

Yes

No

Consider referral to urology/ urogynaecology

Treatment not appropriate / failure

Treatment failure

Mirabegron 50mg od **or**
Vibegron▼ 75mg od

Mirabegron - BP should be measured before starting treatment and monitored regularly, especially in patients with pre-existing hypertension.

Treatment success

Supporting information

This guideline offers best practice advice on the pharmacological management of adults with overactive bladder. Treatment and care should take into account individual needs and preferences. Patients should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

What constitutes a treatment success/failure?
Drug treatment should be reviewed 4 weeks after the start of each treatment. NICE guidance[1] recommends the use of incontinence specific, quality of life scales (e.g. the International Consultation on Incontinence patient questionnaire (ICIQ)). Treatment failure can be concluded if:

- There is no improvement in OAB symptoms
- There is suboptimal improvement
- There are intolerable adverse effects

Anticholinergics (antimuscarinics)

Before treatment starts take into account coexisting conditions, the use of other medicines that affect the total anticholinergic cognitive burden (ACB) and the risk of adverse effects (for example, increased with concomitant treatment with other drugs with anticholinergic side effects).

For more information on co-prescribing of medication with anticholinergic properties, see the PrescQIPP Bulletin 253 Anticholinergic Burden (free registration required).

It is beneficial to discuss with all patients[1]:

- The likelihood of success and common adverse effects **and**
- The frequency and route of administration, **and**
- Some adverse effects such as dry mouth and constipation may indicate that treatment is starting to have an effect, **and**
- That they may not see the full benefits until they have taken the treatment for at least 4 weeks

For additional information on specific drugs see the SPC.

Beta-3 adrenoreceptor agonists:

Mirabegron and vibegron▼ show similar efficacy to anticholinergic drugs but have a different side effect profile. NICE recommends them as an option for treating the symptoms of overactive bladder for people in whom anticholinergic drugs are contraindicated or clinically ineffective or have unacceptable side effects. They do not score on the anticholinergic cognitive burden scale, so could be considered as an alternative for patients who have a high ACB score, if trospium is not suitable.
Mirabegron is contraindicated in uncontrolled hypertension and requires regular BP monitoring, particularly in patients with existing hypertension. This is not required for vibegron, as it is more specific than mirabegron for beta-3 receptors found in bladder tissue. Also, vibegron does not have the CYP3A4/P-gp drug interactions of mirabegron. NICE TA999 assessed vibegron under a cost comparison appraisal and considered it is likely to be cost saving compared with mirabegron. However, it is a black triangle drug with limited experience of prescribing in a wider population.

Mirabegron SPC	NICE TA290 Mirabegron for treating symptoms of overactive bladder (2013)
Vibegron SPC	NICE TA999 Vibegron for treating symptoms of overactive bladder syndrome (2024)

References

1. NG123 Urinary Incontinence and pelvic organ prolapse in women (2019)
2. CG97 Lower urinary tract symptoms: the management of lower urinary tract symptoms in men. (2010 last updated 2015)
3. NG210 Pelvic floor dysfunction: prevention and non-surgical management (2021)

PRESS Portal Resources

Adult continence clinical pathway
Continence assessment Bladder diary