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PRESCRIPTION COMPOUNDING FOR

OBSTETRICS & GYNECOLOGY

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Web: www.NorlandAvenuePharmacy.com
PERIANAL PAIN AFTER CHILDBIRTH

The following study concludes that rectal diclofenac provides effective analgesia after perineal repair -“Effective analgesia following perineal injury during childbirth: a placebo controlled trial of prophylactic rectal diclofenac” (Br J Obstet Gynaecol. 1998 Jun;105(6):627-31).

OBJECTIVE: To determine if diclofenac suppositories administered prophylactically produce effective and lasting analgesia following perineal injury.

DESIGN: A randomised double blind placebo controlled trial.

SETTING: York District Hospital.

POPULATION: One hundred women sustaining objective perineal injury (second degree tear or episiotomy) during spontaneous vaginal delivery at term.

METHODS: Suppositories were administered at the time of repair and approximately 12 hours later. The suppositories were randomised prior to issue by the pharmacy department and contained either 100 mg diclofenac or placebo.

MAIN OUTCOME MEASURES: Pain scores assessed at 12, 24, 48 and 72 hours after delivery using a six point numerical scoring system and the use of additional analgesia and local treatments to the perineum.

RESULTS: The mean pain score was significantly reduced in the diclofenac group at 24, 48 and 72 hours after delivery (0.86, 0.7 and 0.59, respectively) compared with the control group (1.64, 1.31 and 1.5; P < 0.005). In addition there was less supplementary analgesia required (eight women only at 72 hours compared with 15 in the control group) and this was limited to paracetamol or topical treatments to the perineum.

CONCLUSION: Prophylactic rectal diclofenac provides effective analgesia after perineal repair and its effect appears to be maintained into the second and third postpartum days. PMID: 9647153

With our state of the art compounding lab and pharmaceutical knowledge and experience, we can compound diclofenac suppositories in a variety of strengths.

An example of how you might prescribe follows:

<table>
<thead>
<tr>
<th>COMPOUNDED MEDICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diclofenac 100mg</strong></td>
</tr>
<tr>
<td><strong>Suppository</strong></td>
</tr>
<tr>
<td>12 each</td>
</tr>
<tr>
<td>Insert 1 suppository in rectum BID PRN</td>
</tr>
</tbody>
</table>
LOW SEXUAL DESIRE

The following clinical paper states that there is substantial body of evidence from randomized placebo-controlled trials that low-dose testosterone treatment is efficacious in women with low sexual desire disorder - “Role of testosterone in the treatment of hypoactive sexual desire disorder” (Maturitas. 2009 Jun 20;63 (2):152-9).

ABSTRACT: “Hypoactive sexual desire disorder (HSDD) is a common clinical problem that may have a very negative impact on a woman’s quality of life. Diagnosis and treatment is challenging, as one must keep in mind the complex web of factors influencing sexual functioning alone or in concert. Data suggest that androgens are significant independent factors affecting sexual desire, sexual activity and satisfaction, as well as other components of women’s health such as mood and energy. For decades, physicians used various androgen preparations to improve sexual function in women, based on the results of smaller clinical trials and personal clinical observations when taking care of patients. Today, there is substantial body of evidence from randomized placebo-controlled trials that low-dose testosterone treatment is efficacious in women with HSDD who have an established cause of androgen deficiency such as surgical menopause. Recent data support the hypotheses that androgens may also be beneficial in naturally menopausal women or in premenopausal women with low circulating testosterone levels and a decrease in satisfying sexual activity. No single testosterone level has been found to be predictive for low female sexual function, even though women suffering from HSDD commonly have low testosterone levels. The most frequently reported side effects of testosterone treatment are mild hirsutism or acne. Long-term safety is not yet established. Several clinical trials are in progress to further investigate potential benefits and risks of androgen treatment in women with sexual dysfunction.” PMID: 19359109

This clinical paper states that transdermal testosterone has been shown to be effective in treating women with low sexual desire disorder - “Menopause and sexual desire: the role of testosterone” (Menopause Int. 2010 Dec;16(4):162-8).

ABSTRACT: “The present short review underlines the role of testosterone (T) in the motivational and satisfaction components of women's sexuality and critically discusses the strategies to treat hypoactive sexual desire disorder (HSDD), a condition of low desire associated with personal and/or interpersonal difficulties, which is more common in surgical menopausal women. There are multiple ways androgens target the brain regions (hypothalamic, limbic and cortical) involved in sexual function and behaviour. Even though circulating available androgens have been implicated in several domains of sexual response, they seem to be related weakly to symptoms, such as low sexual desire, poor sexual arousal, orgasm and diminished well-being in postmenopausal women. The possibilities of treating low sexual desire/HSDD are multifaceted and should include the combination of pharmacological treatments able to maximize biological signals driving the sexual response, and individualized psychosocial therapies in order to overcome personal and relational difficulties. Transdermal T has been shown to be effective at a dose of 300 µg/day both in surgically and naturally menopausal women replaced with estrogen or not, without any relevant side-effects. However, the decision to treat postmenopausal women with HSDD with T is mainly based on clinical judgment, after informed consent regarding the unknown long-term risks.” PMID: 21156854

An example of how you might prescribe follows:

**COMPOUNDED MEDICATION**

**Testosterone 1%**

**Vaginal Cream**

30gm

Apply 1gm 30 minutes prior to sexual relations

With our state of the art compounding lab and pharmaceutical knowledge and experience, we can compound testosterone in a variety of forms and strengths to meet the needs of your individual patients.
UROGENITAL AGING & ATROPHY

The following study results show that intravaginal administration of estriol may represent a satisfactory therapeutic choice for those postmenopausal women with urogenital tract disturbances. “Efficacy of low-dose intravaginal estriol on urogenital aging in postmenopausal women” (Menopause, 2004 Jan-Feb;11(1):49-56).

OBJECTIVE: To assess the efficacy and safety of intravaginal estriol administration on urinary incontinence, urogenital atrophy, and recurrent urinary tract infections in postmenopausal women.

DESIGN: Eighty-eight postmenopausal women with urogenital aging symptoms were enrolled in this prospective, randomized, placebo-controlled study. Participants were randomly divided into two groups, with each group consisting of 44 women. Women in the treatment group received intravaginal estriol ovules: 1 ovule (1 mg) once daily for 2 weeks and then 2 ovules once weekly for a total of 6 months as maintenance therapy. Women in the control group received inert placebo vaginal suppositories in a similar regimen. We evaluated urogenital symptomatology, urine cultures, colposcopic findings, urethral cytoclogic findings, urethral pressure profiles, and urethrocystometry before as well as after 6 months of treatment.

RESULTS: After therapy, the symptoms and signs of urogenital atrophy significantly improved in the treatment group in comparison with the control group. Thirty (68%) of the treated participants, and only seven (16%) of the control participants registered a subjective improvement of their incontinence. In the treated participants, we observed significant improvements of colposcopic findings, and there were statistically significant increases in mean maximum urethral pressure, in mean urethral closure pressure as well as in the abdominal pressure transmission ratio to the proximal urethra. Urethrocystometry showed positive but not statistically significant modifications.

CONCLUSIONS: Our results show that intravaginal administration of estriol may represent a satisfactory therapeutic choice for those postmenopausal women with urogenital tract disturbances who have contraindications or refuse to undergo standard hormone therapy. PMID: 14716182

This study found that estriol cream was effective in relieving urogenital atrophy for breast cancer survivors. “Low-dose vaginal estrogens or vaginal moisturizer in breast cancer survivors with urogenital atrophy: a preliminary study” (Gynecol Endocrinol, 2010 Jun;26(6):404-12).

ABSTRACT: “The study aim is to evaluate the efficacy and safety of two low-dose vaginal estrogen treatments (ETs) and of a non-hormonal vaginal moisturizer in postmenopausal breast cancer survivors with urogenital atrophy. Eighteen patients receiving estriol cream 0.25 mg (n = 10) or estradiol tablets 12.5 microg (n = 8) twice/week for 12 weeks were evaluated and compared with eight patients treated with polycarbophil-based moisturizer 2.5 g twice/week. Severity of vaginal atrophy was assessed using subjective [Vaginal Symptoms Score (VSS), Profile of Female Sexual Function (PFSF)] and objective [Vaginal Health Index (VHI), Karyopycnotic Index (KI)] evaluations, while safety by measuring endometrial thickness and serum sex hormones levels. After 4 weeks, VSS and VHI were significantly improved by both vaginal ETs, with further improvement after 12 weeks. PFSF improved significantly only in estriol group (p = 0.02). Safety measurements did not significantly change. Vaginal moisturizer improved VSS at week 4 (p = 0.01), but score returned to pre-treatment values at week 12; no significant modification of VHI, KI, PFSF was recorded. Both low-dose vaginal ET are effective for relieving urogenital atrophy, while non-hormonal moisturizer only provides transient benefit. The increase of serum estrogens levels during treatment with vaginal estrogen at these dosages is minimal.” PMID: 20196634

An example of how you might prescribe follows:

**COMPOUNDED MEDICATION**

<table>
<thead>
<tr>
<th>Estriol 0.1% Vaginal Cream</th>
<th>30gm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insert 1gm intravaginally once daily for 2 weeks, then twice weekly thereafter</td>
<td></td>
</tr>
</tbody>
</table>

We have the ability to compound estriol as a vaginal cream.
Prescriber Name

Prescriber Address

City __________________________ State ___________ Zip ____________

Phone ______________ Fax __________

Date ___________ Patient Name ________________________________ DOB __________

Address __________________________ City/State/Zip ______________________ Phone __________

☐ Patient will pick up at pharmacy ☐ Please ship to patient

☐ Bill Insurance Plan: ___________________________ ID# __________________________

All topical compound %s are per 1 ml or 1 gm unless otherwise noted

<table>
<thead>
<tr>
<th><strong>Perianal Pain after Childbirth</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Diclofenac 100mg Suppository</td>
</tr>
<tr>
<td>Quantity 12 each</td>
</tr>
<tr>
<td>Directions: Insert 1 suppository in rectum BID PRN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Low Sexual Desire</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Testosterone 1% Vaginal Cream</td>
</tr>
<tr>
<td>Quantity 30gm</td>
</tr>
<tr>
<td>Directions: Apply 1 gm 30 minutes prior to sexual relations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Urogenital Aging &amp; Atrophy</strong></th>
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</thead>
<tbody>
<tr>
<td>[ ] Estriol 0.1% Vaginal Cream</td>
</tr>
<tr>
<td>Quantity 30gm</td>
</tr>
<tr>
<td>Directions: Insert 1 gm intravaginally once daily for 2 weeks, then twice weekly thereafter</td>
</tr>
</tbody>
</table>

Directions

Prescriber’s Signature ___________________________ Refills: 1 2 3 4 5 6 7 8 9 10 11 12 NR