

## Prescribing Information

### Oestrogel (estradiol) Pump-Pack 750 micrograms/actuation Gel

For full prescribing information, including side effects, precautions and contraindications, please consult the Summary of Product Characteristics (SmPC). **Presentation:** Transdermal gel. One gram of gel contains 0.6 mg of the active ingredient, estradiol (0.06% w/w). Each pump actuation delivers 1.25 g of gel which contains 0.75 mg of estradiol. **Indication:** 1. Hormone Replacement Therapy (HRT) for oestrogen deficiency symptoms in postmenopausal women. 2. Prevention of osteoporosis in postmenopausal women at high risk of future fractures who are intolerant of, or contraindicated for, other medicinal products approved for the prevention of osteoporosis. The experience treating women older than 65 years is limited. **Posology:** *Dosing in women without a uterus:* Oestrogel should be administered daily on a continuous basis. Unless there is a previous diagnosis of endometriosis, it is not recommended to add a progestogen in hysterectomised women. *Dosing in women with an intact uterus:* consideration should be given to the addition of a progestagen including progesterone for at least 12 to 14 days every month / 28-day cycle to reduce the risk of endometrial hyperplasia and carcinoma. Oestrogel should be administered daily on a continuous sequential basis. *Menopausal and postmenopausal symptoms:* Each metered dose (1 pump actuation) from the dispenser is 1.25 g of Oestrogel. Two pumps (2.5 g) of Oestrogel once daily (1.5 mg estradiol) is the usual starting dose. If after one month's treatment effective relief is not obtained, the dosage may be increased accordingly to a maximum of four pumps (5 g) of Oestrogel daily (3.0 mg estradiol). For initiation and continuation of treatment of postmenopausal symptoms, the lowest effective dose for the shortest duration should be used. *Postmenopausal osteoporosis:* The usual dose is two actuations (2.5 g of gel, which contains 1.5 mg estradiol) once daily. The lowest effective dose for the prevention of osteoporosis is not known.

**Method of administration:** For local cutaneous use. Before using a new pump pack, it will require priming; the first dose of gel dispensed should be discarded. The patient should apply the gel herself and avoid skin contact with others, particularly a male partner, for at least 1 hour after application. Wash hands with soap and water after applying the gel. Secondary exposure to estradiol can potentially occur as a result of passive transfer following skin-to-skin contact. Patients should be informed that others, especially children, should not come in contact with the area of the body where Oestrogel was applied on. The gel dose should be dispensed and applied to clean, dry, intact areas of skin e.g. on the arms and shoulders, or inner thighs. A thin layer of the gel should be applied to the entire arm on the inside and outside from wrist to shoulder or inner thigh. The area of application should be as large as possible. Oestrogel should not be applied on or near the breasts or on the vulval region. A frequent change in application sites is recommended. The gel must be allowed to dry for 5 minutes before covering the skin with clothing. There is no relevant use of Oestrogel in children aged less than 12 years. **Contraindications:** Known hypersensitivity to the active substances or to any of the excipients; Known, past or suspected breast cancer; known or suspected oestrogen-dependent malignant tumours (e.g. endometrial cancer); undiagnosed genital bleeding; untreated endometrial hyperplasia; previous or current venous thromboembolism (e.g. deep vein thrombosis, pulmonary embolism); known thrombophilic disorders (e.g. protein C, protein S, or antithrombin deficiency), active or recent arterial thromboembolic disease (e.g. angina, myocardial infarction); acute liver disease or a history of liver disease as long as liver function tests have failed to return to normal; porphyria.

**Warnings and Precautions for use:** This medicine is for external use only and should not be swallowed. Care should be taken to ensure cleanliness of the skin and hands during application. Do not apply to damaged skin. For the treatment of postmenopausal symptoms: HRT should only be initiated for symptoms that adversely affect quality of life. The risks and benefits should be reviewed annually and HRT only continued as long as the benefit outweighs the risk. A personal and family medical history should be taken before initiating or reinstating HRT. Periodic check-ups are recommended during treatment. Women should be advised what changes in their breasts should be reported to their doctor or nurse. Physical examination and investigations including appropriate imaging tools should be carried out according to the clinical needs of the patient.

Patients should be closely supervised if any of the following conditions are present, have occurred previously and/or have been aggravated during pregnancy or previous hormone treatment since they may recur or be aggravated during treatment with Oestrogel: leiomyoma (uterine fibroids) or endometriosis; risk factors for thromboembolic disorders; risk factors for oestrogen-dependent tumours; hypertension; liver disorders; diabetes mellitus with or without vascular involvement; cholelithiasis; migraine or severe headache; systemic lupus erythematosus; history of endometrial hyperplasia; epilepsy; asthma and otosclerosis. Oestrogel should be discontinued if a contraindication is discovered or the following occur: jaundice or deterioration in liver function; significant increase in blood pressure; new onset of migraine-type headache; pregnancy. In women with an intact uterus the risk of endometrial hyperplasia and carcinoma is increased when oestrogens are administered alone for prolonged periods of time. The addition of a progestogen cyclically for at least 12 days per month/28 day cycle or continuous combined oestrogen-progestogen therapy in non-hysterectomised women prevents the excess risk associated with oestrogen-only HRT. Break-through bleeding and spotting may occur during the first months of treatment but if they occur after some time on therapy or continue after treatment has been discontinued the reason should be investigated. Unopposed oestrogen stimulation may lead to premalignant or malignant transformation in the residual foci of endometriosis. Therefore, the addition of progestogens to oestrogen replacement therapy should be considered in women who have undergone hysterectomy because of endometriosis if they are known to have residual endometriosis. Evidence shows an increased risk of breast cancer in women taking combined oestrogen-progestogen or oestrogen-only HRT that is dependent on the duration of taking HRT. HRT, especially oestrogen-progestogen combined treatment, increases the density of mammographic images which may adversely affect the radiological detection of breast cancer. Epidemiological evidence from a large meta-analysis suggests a slightly increased risk of ovarian cancer in women taking oestrogen-only or combined oestrogen-progestogen HRT which becomes apparent within 5 years of use and diminishes over time after stopping. HRT is associated with a 1.3 to 3-fold risk of developing venous thromboembolism. The occurrence of such an event is more likely in the first year of HRT than later. It is recommended to stop HRT 4 to 6 weeks prior to elective surgery if prolonged immobilisation is to follow. The benefit-risk of HRT should be considered in women already on chronic anticoagulant treatment. If venous thromboembolism occurs during treatment, HRT should be discontinued. Patients should contact their doctors immediately if they have potential thromboembolic symptoms. The relative risk of coronary artery disease (CAD) during use of combined oestrogen + progestogen HRT is slightly increased. As the baseline absolute risk of CAD is strongly dependent on age, the number of extra cases of CAD due to oestrogen and progestogen use is very low in healthy women close to menopause, but will rise with more advanced age. Combined oestrogen-progestogen and oestrogen-only therapy are associated with up to a 1.5-fold increase in risk of ischaemic stroke. The relative risk does not change with age or time since menopause. However, as the baseline risk of stroke is strongly age-dependent, the overall risk of stroke in women who use HRT will increase with age. Care should be taken with women with cardiac or renal dysfunction since oestrogens may cause fluid retention. Women with pre-existing hypertriglyceridaemia should be followed closely during oestrogen replacement or HRT since pancreatitis can result from rare cases of large increases in plasma triglycerides. Oestrogens increase thyroid binding globulin (TBG), leading to increased circulating total thyroid hormone. Other binding proteins may be elevated in serum, i.e. corticoid binding globulin (CBG), sex-hormone-binding globulin (SHBG) leading to increased circulating corticosteroids and sex steroids respectively. Other plasma proteins may be increased (angiotensinogen/renin substrate, alpha-1-antitrypsin, ceruloplasmin). HRT use does not improve cognitive function. There is some evidence of increased risk of probable dementia in women who start HRT after the age of 65. **Interactions:** Patients should avoid strong skin cleaners and detergents, skin products of high alcoholic content (e.g. astringents, sunscreens) and keratolytics which may alter the barrier structure or function of the skin. Use of any concomitant skin medication which alters skin production (e.g. cytotoxic drugs) should be avoided. The metabolism of oestrogens may be increased by concomitant use of substances known to induce drug-metabolising enzymes, specifically cytochrome P450 enzymes, such as anticonvulsants (e.g. phenobarbital, phenytoin, carbamazepine) and anti-infectives (e.g. rifampicin, rifabutin, nevirapine, efavirenz). Ritonavir and nelfinavir exhibit inducing properties when used concomitantly with steroid hormones. Herbal preparations containing St John's wort (*Hypericum perforatum*) may induce the metabolism of oestrogens. Transdermally

applied oestrogens may be less affected by enzyme inducers than oral hormones. Clinically, an increased metabolism of oestrogens and progestogens may lead to decreased effect and changes in the uterine bleeding profile. **Fertility, pregnancy and lactation:** Oestrogel is not indicated in pregnancy. Pregnancy should be excluded before initiating HRT. If pregnancy occurs during medication with Oestrogel, the treatment should be withdrawn immediately. The data relating to inadvertent foetal exposure to oestrogens indicate no teratogenic or foetotoxic effects. Oestrogel is not indicated during lactation. **Effects on ability to drive and use machines:** Oestrogel has no or negligible influence on the ability to drive and use machines. **Undesirable effects:** Undesirable effects are generally mild and rarely require treatment withdrawal. Undesirable effects, if any, usually occur during the first months of treatment. The following undesirable effects are observed with estradiol at a common frequency ( $\geq 1/100$ ;  $\leq 1/10$ ): headache, nausea, abdominal pain, breast swelling/pain, breast enlargement, dysmenorrhoea, menorrhagia, metrorrhagia, leucorrhoea discharge, endometrial hyperplasia, weight change (increase or decrease), water retention with peripheral oedema; uncommon frequency ( $\geq 1/1,000$ ;  $\leq 1/100$ ): depression, mood swings, vertigo, migraine, flatulence, vomiting, venous thromboembolic disease, pruritus, increased volume of uterine fibroids, leiomyoma, vaginitis/vaginal candidiasis, Asthenia; rare frequency, ( $\geq 1/10,000$ ;  $\leq 1/1,000$ ): glucose intolerance, change in libido, aggravation of epilepsy, arterial hypertension, liver function tests abnormalities, cholestasis and jaundice, skin decolouration, acne, bone pain, anaphylactic reaction (in women with past history of allergic reaction); very rare frequency ( $<1/10,000$ ): contact lens intolerance. The following adverse reactions have also been reported in association with systemic oestrogen/ progestogen treatment: rash, chloasma/melasma, vomiting, abdominal pain, breast tenderness, breast enlargement, fluid retention/oedema, weight changes, changes in libido, depression, gall bladder disease, probable dementia over the age of 65, skin and subcutaneous disorders: erythema multiforme, erythema nodosum, vascular purpura. For further information on side effects and risk estimates, please consult the SPC. **Overdose:** Overdosage is unlikely with transdermal applications. Pain in the breasts or excessive production of cervical mucus may be indicative of too high a dosage. Overdoses of oestrogen may cause nausea vomiting and withdrawal bleeding. These signs disappear when the treatment is stopped or when the dose is reduced. There are no specific antidotes and treatment should be symptomatic. **NHS Price:** 80g dispenser £9.15. **Legal category:** POM. **Marketing Authorisation number:** PL 28397/0002. **Marketing Authorisation Holder:** Besins Healthcare, Rue Washington 80, 1050 Ixelles, Belgium. **Date of preparation of Prescribing Information:** May 2025 MAT-PROMO-OES-0250

**Adverse events should be reported.**

Reporting forms and information can be found at [yellowcard.mhra.gov.uk](https://yellowcard.mhra.gov.uk) or search for MHRA Yellow Card in the Google Play or Apple App Store.

Adverse events should also be reported to Besins Healthcare

(UK) Ltd, Drug Safety on 0203 862 0920

Email: [drugsafety@besins-healthcare.com](mailto:drugsafety@besins-healthcare.com)

## Prescribing Information

### Utrogestan (progesterone) 100 mg capsules

For full prescribing information, including side effects, precautions and contraindications, please consult the Summary of Product Characteristics (SmPC).

**Presentation:** Round, slightly yellow soft capsule, containing with whitish oily suspension white containing 100 mg progesterone. **Indication:** Adjunctive use with oestrogen in post- menopausal women with an intact uterus as hormone replacement therapy (HRT). **Dosage and administration:** In women receiving estrogen replacement therapy there is an increased risk of endometrial cancer which can be countered by progesterone administration. The recommended dose is 200 mg daily at bedtime for twelve days in the last half of each therapeutic cycle (beginning on Day 15 of the cycle and ending on Day 26). Withdrawal bleeding may occur in the following week. Alternatively, 100 mg can be given at bedtime from Day 1 to Day 25 of each therapeutic cycle, withdrawal bleeding being less with this treatment schedule. For initiation and continuation of treatment of postmenopausal symptoms, the lowest effective dose for shortest duration should be used. Dose for older people is the same. Not indicated in pre-pubescent children. Oral capsules should not be taken with food as this increases the bioavailability of progesterone and should be taken at bedtime. **Contraindications:** When used in conjunction with estrogens, Utrogestan should not be used in patients with any of the following conditions: Hypersensitivity to the active substance soya, peanut or to any of the excipients, known past or suspected breast cancer; known or suspected hormone-dependent malignant tumours (e.g. endometrial cancer); undiagnosed vaginal (genital) bleeding; untreated endometrial hyperplasia; previous or current thromboembolism (e.g. deep venous thrombosis, pulmonary embolism, thromboembolic disorders) or thrombophlebitis; known thrombophilic disorders (e.g. protein S, protein C, or antithrombin deficiency); active or recent arterial thromboembolic disease (e.g., angina pectoris, myocardial infarction); acute liver disease or history of liver disease as long as liver function tests have failed to return to normal; porphyria; cerebral haemorrhage has been observed with synthetic progestogens; breast-feeding. **Warnings and Precautions:** Utrogestan is not suitable as a contraceptive and must only be used in accordance with the indications. For the treatment of postmenopausal symptoms, HRT should only be initiated for symptoms that adversely affect quality of life. A careful appraisal of the risks and benefits should be undertaken at least annually and HRT should only be continued as long as the benefit outweighs the risk. Before initiating or reinstating HRT, a complete personal and family medical history should be taken. During treatment, periodic check-ups are recommended. Women should be advised what changes in their breast should be reported to their doctor or nurse. Investigations, including appropriate imaging tools, e.g. mammography, should be carried out in accordance with currently accepted screening practices, modified to the clinical needs of the individual. Patients should be closely supervised if any of the following conditions are present, have occurred previously and/or have been aggravated during pregnancy or previous hormone treatment since they may recur or be aggravated during treatment with Utrogestan 100 mg capsules; leiomyoma (uterine fibroids) or endometriosis; risk factors for thromboembolic disorders, risk factors for oestrogen dependent tumours (e.g. 1<sup>st</sup> degree heredity for breast cancer), hypertension, liver disorders (e.g. liver adenoma); diabetes mellitus with or without vascular involvement; cholelithiasis; migraine or severe headache; systemic lupus erythematosus; a history of endometrial hyperplasia; epilepsy; asthma; otosclerosis; depression; photosensitivity. Therapy should be immediately discontinued in case a contra-indication is discovered and in the following situations: jaundice or deterioration in liver function, significant increase in blood pressure, new onset of migraine- type headache, pregnancy, sudden or gradual, partial or complete loss of vision; venous or thrombotic thromboembolic accidents regardless of the territory; proptosis or diplopia, papilloedema, retinal vascular lesions. Endometrial hyperplasia and carcinoma; the addition of progesterone for at least 12 days per month/28 day cycle or continuous combined estrogen-progestogen therapy in non-hysterectomised women prevents the excess risk associated with estrogen-only HRT. If breakthrough bleeding or spotting appears after some time on therapy, or continues after treatment has been discontinued, the reason should be investigated. Breast cancer; the overall evidence suggests an increased risk of breast cancer in women taking combined estrogen-progestogen and possibly also estrogen-only HRT, that is dependent on the duration of taking HRT. The excess risk becomes apparent within a few years of use but returns to baseline within a few (at most five) years after stopping treatment. HRT, especially estrogen- progestogen combined treatment, increases the density of mammographic images which may adversely affect the radiological detection of breast cancer. Ovarian cancer; epidemiological evidence from a large meta- analysis suggests a slightly increased risk in women taking estrogen-only or combined estrogen-progestogen HRT, which becomes apparent within 5 years of use and diminishes over time after stopping. Venous Thromboembolism (VTE); HRT is associated with a 1.3-3-fold risk of developing VTE. The occurrence of such an event is more likely in the first year of developing VTE. The occurrence of such an event is more likely in the first year of HRT than later. If prolonged immobilisation is to follow elective surgery temporarily stopping HRT 4 to 6 weeks earlier is recommended. Women already on chronic anticoagulant treatment require careful consideration of the benefit-risk of use of HRT. If VTE develops after initiating therapy, the drug should be discontinued. Patients should be told to contact their doctors immediately when they are aware of a potential

thromboembolic symptom. The relative risk of coronary artery disease during use of combined estrogen + progesterone HRT is slightly increased. Combined estrogen-progestogen and estrogen-only therapy are associated with an up to 1.5-fold increase in risk of ischaemic stroke. HRT use does not improve cognitive function. There is some evidence of increased risk of probable dementia in women who start using continuous combined or estrogen-only HRT after the age of 65. Utrogestan 100 mg capsules contain soybean lecithin and may cause hypersensitivity reactions (urticaria and anaphylactic shock) in hypersensitive patients. As there is a possible relationship between allergy to soya and allergy to peanut, patients with peanut allergy must avoid using this medicine. Utrogestan contain highly refined oil, for which the incidence of hypersensitivity is very rare in adults. **Interactions:** Progestogens may affect the treatment balance of diabetes and an adjustment in anti-diabetic dosage may be required. Progesterone may: enhance or weaken the anticoagulant effect of coumarins and prevent the anticoagulant effect of phenindione; increase the plasma concentration of tizanamide and ciclosporin and risk of toxicity; interfere with the effects of bromocriptine, enhance the arrhythmogenicity of bupivacaine; alter results of liver and/or endocrine function tests; prevent oxidation of some benzodiazepine derivatives such as diazepam, chlordiazepoxide and alprazolam and to induce glucuronidation of oxazepam and lorazepam. Drugs that may increase metabolism of progesterone: Peramppanel or topiramate; some antibiotics (ampicillin, amoxicillin and tetracycline) may lower plasma concentrations of steroids; rifampicin and rifabutin; epilepsy medicines (phenytoin, phenobarbital, carbamazepine, eslicarbazepine, oxcarbazepine and primidone/rufinamide) not valproic acid; herbal medicinal products containing St John's wort (Hypericum perforatum); antiretroviral medicines (protease blockers): darunavir, nelfinavir, fosamprenavir, lopinavir; bosentan; aprepitant. Antifungal medicines (fluconazole, itraconazole, ketoconazole, voriconazole), immunosuppressants (tacrolimus), statins (atorvastatin, rosuvastatin) and monoamine oxidase (MAO) inhibitors (selegiline) may prevent the metabolism of progesterone which leads to an increase in the bioavailability of progesterone. **Fertility, Pregnancy and lactation:** If pregnancy occurs medication, should be withdrawn immediately. The data relating to inadvertent foetal exposure to combinations of estrogens + progesterone indicate no teratogenic or foetotoxic effect. Prescription of progesterone beyond the first trimester may reveal gravidic cholestasis. Utrogestan 100mg is Not indicated during breast-feeding. Progesterone is distributed into breast milk. **Effects on ability to drive and use machines:** Utrogestan 100mg May cause drowsiness or dizziness; therefore care should be taken when driving or using machines. Taking the capsules at bedtime helps avoids these drawbacks. **Undesirable effects:** Post marketing experience, from oral administration of progesterone: Common adverse reactions (≥1/100; <1/10): occur with this medicine: weight fluctuation, insomnia, dizziness, headache, somnolence, abdominal distension, abdominal pain, nausea, pruritus, intermenstrual bleeding, vaginal haemorrhage, menstruation irregular, amenorrhoea, metrorrhagia, breast pain and breast tenderness, breakthrough bleeding or irregular withdrawal bleeding, fatigue, malaise. Uncommon adverse reactions (≥1/1000; <1/100): occur with this medicine: thromboembolic disorder, fluid retention, agitation, anxiety, apathy, depression, disorientation, mood swings, nervousness, amnesia, migraine, paraesthesia, speech disorder, syncope, visual disturbance, tinnitus, vertigo, palpitations, tachycardia, haemorrhage, hot flush, hypotension, thrombotic events (mainly when taken in combination with estrogen), dyspnoea, constipation, diarrhoea, vomiting, non-severe and reversible liver disorders, cholestatic jaundice, acne, alopecia, erythema, hyperhidrosis, rash, urticaria, arthralgia, back pain, limb discomfort, muscle spasms, myalgia, abnormal withdrawal bleeding, breast discomfort, endometrial hyperplasia, vaginal discharge, vulvovaginal discomfort, menstrual cycle abnormal, mastodynia, hirsutism, asthenia, chest discomfort, chest pain, oedema. Rare adverse events (≥1/10000; <1/1000): occur with this medicine: eye irritation, loss of appetite, dysuria, anaphylactoid reactions. Please refer to the SmPC for further information. **Overdose:** Symptoms may include drowsiness, somnolence, or fatigue. Treatment of overdosage consists of discontinuation of Utrogestan together with institution of appropriate symptomatic and supportive care **NHS Price:** £6.60 for 30 capsules. **Legal category:** POM. **Marketing Authorisation Number:** PL 28397/0003. Marketing Authorisation Holder: Besins Healthcare, Rue Washington 80, 1050 Ixelles, Belgium. **Date of preparation of prescribing information:** February 2025 MAT-BHUK-UTO-0028

#### Adverse events should be reported.

Reporting forms and information can be found at  
[www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard) or search for MHRA Yellow Card in the  
Google Play or Apple App Store.  
Adverse events should also be reported to Besins Healthcare (UK) Ltd,  
Drug Safety on 0203 862 0920  
Email: [pharmacovigilance@besins-healthcare.com](mailto:pharmacovigilance@besins-healthcare.com)

## Prescribing Information

### Imvaggis (Estriol) 0.03 mg pessary

For full prescribing information, including side effects, precautions and contraindications, please consult the Summary of Product Characteristics (SmPC).

**Presentation:** 1 pessary contains 0.03 mg estriol. Each pessary contains a maximum of 0.008 mg butylhydroxytoluene. **Indication:** Local treatment of vaginal symptoms of estrogen deficiency in postmenopausal women. **Posology and method of administration:** During the first 3 weeks of treatment, 1 pessary is administered daily. Thereafter, a maintenance dose of 1 pessary twice a week is recommended. For initiation and continuation of treatment of postmenopausal symptoms, the lowest effective dose for the shortest duration should be used. For estrogen products for vaginal application of which the systemic exposure to the estrogen is very low, it is not recommended to add a progestogen. The pessary should be introduced deeply into the vagina, preferably in the evening before going to bed. **Contraindications:** Known, past or suspected breast cancer. Known or suspected estrogen-dependent malignant tumours (e. g. endometrial cancer). Undiagnosed genital bleeding. Untreated endometrial hyperplasia. Previous or current venous thromboembolism (deep venous thrombosis, pulmonary embolism). Known thrombophilic disorders (e. g. protein C, protein S, or antithrombin deficiency. Active or recent arterial thromboembolic disease (e.g., angina, myocardial infarction). Acute liver disease, or a history of liver disease as long as liver function tests have failed to return to normal. Porphyrin. Hypersensitivity to the active substance or to any of the excipients. **Warnings and Precautions:** For the treatment of postmenopausal symptoms, HRT should only be initiated for symptoms that adversely affect quality of life. The risks and benefits should be reviewed annually, and HRT should only be continued as long as the benefit outweighs the risk. Imvaggis 0.03 mg pessary must not be combined with estrogen preparations for systemic treatment. Before initiating or reinstating HRT a complete personal and family medical history should be taken. During treatment, periodic check-ups are recommended of a frequency and nature adapted to the individual woman. Women should be advised what changes in their breasts should be reported to their doctor or nurse. Vaginal infections should be treated with the appropriate medication before the start of treatment with Imvaggis 0.03 mg pessary. Patients should be closely supervised if any of the following conditions are present, have occurred previously and/or have been aggravated during pregnancy or previous hormone treatment. It should be taken into account that these conditions may recur or be aggravated during treatment with Imvaggis 0.03 mg pessary, in particular: leiomyoma (uterine fibroids) or endometriosis; risk factors for thromboembolic disorders; risk factors for estrogen-dependent tumours; hypertension; liver disorders; diabetes mellitus with or without vascular involvement; cholelithiasis; migraine or severe headache; systemic lupus erythematosus; history of endometrial hyperplasia; epilepsy; asthma and otosclerosis. Estriol should be discontinued if a contraindication is discovered or the following occur: jaundice or deterioration in liver function; significant increase in blood pressure; new onset of migraine-type headache; pregnancy. An increased risk of endometrial hyperplasia or uterine cancer has not been attributed to treatment with estriol by vaginal use. In women with an intact uterus the risk of endometrial hyperplasia and carcinoma is increased when systemic estrogens are administered alone for prolonged periods. Endometrial safety of long-term (>1 year) or repeated use of local vaginally administered estrogen is uncertain. Therefore, if repeated, treatment should be reviewed at least annually. If bleeding or spotting appears at any time on therapy, the reason should be investigated, which may include endometrial biopsy to exclude endometrial malignancy. The following risks have been associated with systemic HRT and apply to a lesser extent to estrogen products for vaginal application of which the systemic exposure to the estrogen is very low. However they should be considered in case of long term or repeated use of this product. Breast cancer, ovarian cancer, venous thromboembolism, coronary artery disease and ischaemic stroke. Estrogens may cause fluid retention and therefore patients with cardiac or renal dysfunction should be carefully observed. Women with

pre-existing hypertriglyceridemia, should be followed closely during estrogen replacement or hormone replacement therapy, since rare cases of large increases of plasma triglycerides leading to pancreatitis have been reported with estrogen therapy in this condition. Exogenous estrogens may induce or exacerbate symptoms of hereditary and acquired angioedema. Estrogens increase thyroid binding globulin (TBG), leading to increased circulating total thyroid hormone. Other plasma proteins may be increased (angiotensinogen/renin substrate, alpha-1-antitrypsin, ceruloplasmin). Imvaggis 0.03 mg pessary cannot be used for contraception. The excipient butylhydroxytoluene may cause local skin reactions (e.g. contact dermatitis), or irritation to the eyes and mucous membranes. **Interactions:** Due to the vaginal administration and minimal systemic absorption, it is unlikely that any clinically relevant drug interactions will occur with Imvaggis 0.03 mg pessary. However, interactions with other locally applied vaginal treatments should be considered. If Imvaggis 0.03 mg pessary is used simultaneously with condoms made of latex it can decrease the tensile strength and thus impair the safety of condoms. **Pregnancy and lactation:** The use of Imvaggis 0.03 mg pessary is not indicated during pregnancy. If pregnancy occurs during medication with the product, treatment should be withdrawn immediately. Given the high estriol concentrations in human pregnancy, any fetal exposure to estriol due to the use of low-dose pessaries is to be regarded as negligible. Imvaggis 0.03 mg pessary is not indicated during lactation. However, very low doses of vaginally applied estriol are unlikely to interfere with lactation. **Undesirable effects:** At the beginning of treatment, when the vaginal epithelial layers are still atrophic, local irritation may occur as a sensation of heat, pain and/or itching. They are often transient and of mild intensity. The following undesirable effects commonly (>1/100; <1/10) occur: vulvovaginal burning, pruritus, pain and dysuria. The following are uncommon ( $\geq 1/1,000$ ; <1/100): vaginal discharge, anorectal discomfort. Please refer to the SPC for the risks that have been associated with systemic HRT and apply to a lesser extent for estrogen products for vaginal application of which the systemic exposure to estrogen is very low. **Overdose:** Toxicity for estriol is very low. Overdose of Imvaggis 0.03 mg pessary by vaginal application is very unlikely. Symptoms that may occur in the case of a high dose accidentally ingested are nausea, vomiting and vaginal bleeding in females. There is no known antidote. If necessary, a symptomatic treatment should be instituted. **NHS Price:** 24 pessaries, £13.38. **Legal category:** POM. **Marketing Authorisation number:** PL 42714/0001. Marketing Authorisation Holder: Besins Healthcare (UK) Ltd, Lion Court, 25 Proctor Street, Holborn, London, WC1V 6NY, UK. **Date of preparation of Prescribing Information:** July 2024. MAT-BHUK-NP-0132

#### Adverse events should be reported.

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