AFABulous Review:

PEER presents an ode to women's health

Jessica Kirkwood, MD CCFP (AM)
Danielle Perry, MSc RN
Samantha Moe, PharmD

PEER PATIENTS EXPERIENCE EVIDENCE RESEARCH

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

peerevidence.ca

Presenter Disclosure

Danielle Perry MSc BSCN RN

- **Grants/Research Support:** N/A
- **Speakers Bureau/Honoraria:** PEIP, ACFP, Dalhousie CPD, Center for Effective Practice
- **Consulting Fees:** N/A
- **Other:** Salary – CFPC, Correctional Service of Canada

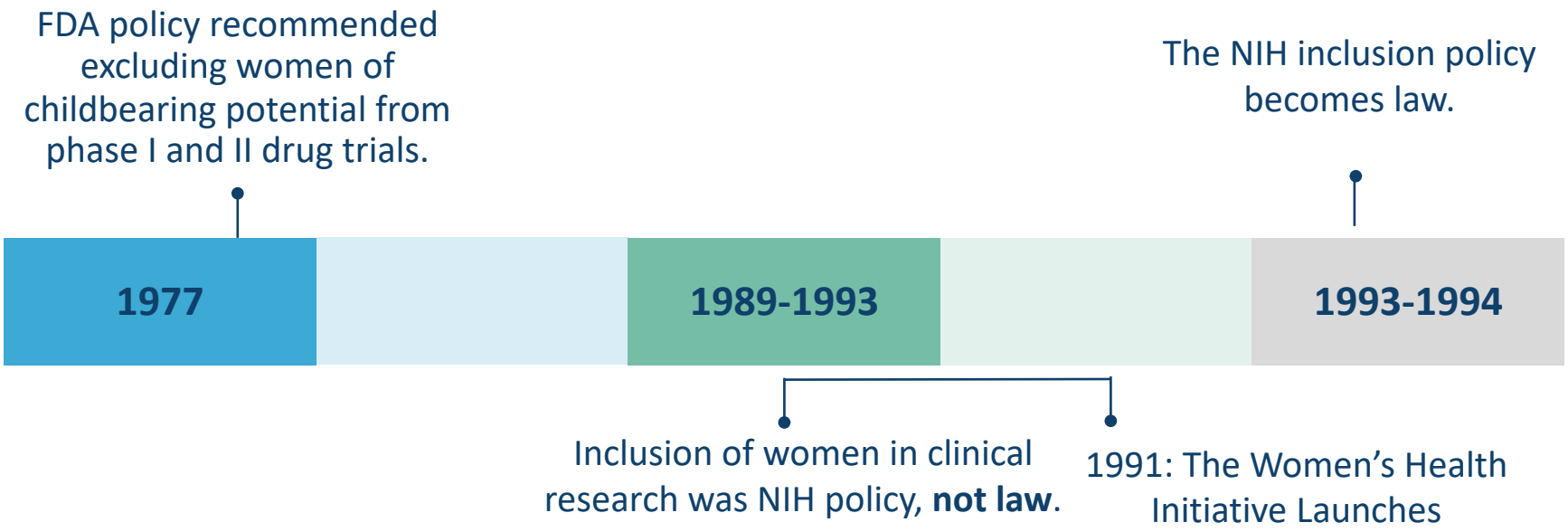
Samantha Moe BScPHM ACPR PharmD

- **Grants/Research Support:** N/A
- **Speakers Bureau/Honoraria:** N/A
- **Consulting Fees:** N/A
- **Other:** Salary - CFPC

Jessica Kirkwood MD CCFP (AM)

- **Grants/Research Support:** N/A
- **Speakers Bureau/Honoraria:** CFPC, PEER, CPSS, ACFP, MEME, PEER/PEIP
- **Consulting Fees:** N/A
- **Other:** Assistant Professor UofA

Women in Research- A Brief Timeline




TEAR HERE • DÉTACHEZ ICI
CELEBRATING
Canadian Women
In Sports!
CÉLÉBRONS
les Canadiennes
du monde des sports!
Cracker
Jill
The
L' Original
COATED POPCORN & PEANUTS
DÉTACHEZ ICI
CELEBRATING
Canadian Women
In Sports!
CÉLÉBRONS
les Canadiennes
du monde des sports!
Cracker
Jill
The
L' Origin

	A Contraception & Menstruation	B Pregnancy & Breastfeeding	C Screening & Diagnosis	D Menopause & other hot topics
1	Etonogestrel Implant (Nexplanon) for contraception	Domperidone for breastfeeding	Decreasing pain during PAP (new study)	Fezolinetant for vasomotor symptoms
2	Extended use IUD	Options for nausea and vomiting in pregnancy	Vaginal swabs for STI	Pessaries & pelvic exercises for stress incontinence
3	Analgesia for IUD insertion	Cabbage for breast engorgement	Endometrial biopsy for diagnosing cancer	Iron formulations for anemia
4	Oral contraceptives and breastfeeding	Caffeine in pregnancy	Cervical screening (New Study)	Strategies to increase sexual desire
5	Options for heavy menstrual bleeding	Antibiotic prophylaxis for operative delivery	OP Screening – what's new	Non-hormonal agents for vasomotor symptoms

PEER Products: Guidelines, tools and much more

PEER Simplified Guidelines

Podcasts

BS Medicine, In the Clinic

Decision Aids and Clinical Calculators

Tools for Practice

Conferences and Live Events

Practical Talks for Family Docs

Price Comparison Document

The PEER Team

Discover

peerevidence.ca

The PEER Simplified Lipid Guideline

2023 Update

A simplified approach to lipid management for busy family doctors!

Read the guideline today!

bit.ly/PEERlipid2023

PEER Patients Experience Evidence Research

The College of Family Physicians of Canada | Le Collège des médecins de famille du Canada

Alberta College of Family Physicians

The Saskatchewan College of Family Physicians | Le Collège des médecins de famille de la Saskatchewan

A chapter of the College of Family Physicians of Canada

Une section du Collège des médecins de famille du Canada

Ontario College of Family Physicians

Sign Up for the PEER Newsletter

Don’t miss out! Get notified when PEER releases new guidelines, clinical tools and more!

Visit peerevidence.ca/newsletter or scan QR Code to join.

Are new oral iron formulations better than ferrous salts?

9 RCTs:

- 80 pts (92% female, mean 39y): Iron polysaccharide vs Fe fumarate; 150mg/day elemental; 12w
  - Fe fumarate: improved Hg more (28g/L vs 6g/L); better Fe, MCV, TSAT; more nausea (31% vs 3%)
- 80 children (mean 23mo): iron polysacch vs Fe sulfate;
  - Fe sulfate: improved Hg more (10g/L at 12w), resolved IDA (29% vs 6%, NNT 5), less diarrhea (35% vs 58%)

Population	Results
Adults (n=43) Premature infants (n=32)	- Iron polysaccharide vs Fe salts: Hg no different at 4-6 weeks
Dialysis (n=62 and 46)	- TSAT, proportion of iron replete pts (6mo): no diff - Ferritin~160ug/L better w/ sulfate
Post gastric bypass (n=14)	Fe sulfate improved Hg at 8w but heme iron did not
Blood donors (n=97), pregnant patients (n=90)	Adding heme iron to Fe fumarate vs Fe fumarate alone: no efficacy differences, - constipation: 14% heme vs 35%

TFP #234, April 2019.

Are new oral iron formulations better than ferrous salts?

New meta-analysis in 2023

Fe bisglycinate vs other irons preparations

- Hg: no difference vs sulfate/fumarate (4RCTs with low bias) among pregnant patients
- Ferritin: no difference
- Adv effects: RR 0.4, favouring bisglycinate (but some flaws in meta-analysis)

Context

Per month: 100mg elemental iron

- Fe fumarate/sulfate (generics): $5-10
- Fe fumarate (Palafer): $35
- Iron polysaccharide (Feramax): $35
- Ferrous bisglycinate: $15-18

Options to reduce GI AE: lower doses, alternating days, lower elemental iron

Bottom Line: Newer iron formulations appear inferior to older ferrous salts. Ferrous salts improve Hg 10-20g/L more and perhaps one in 5 more attain IDA resolution at 3mo. Evidence that newer formulations have less AE is inconsistent.

New Canadian Guideline: Preventing fragility fractures

Screening for the primary prevention of fragility fractures:

- "Risk-assessment first" screening for women 65y+

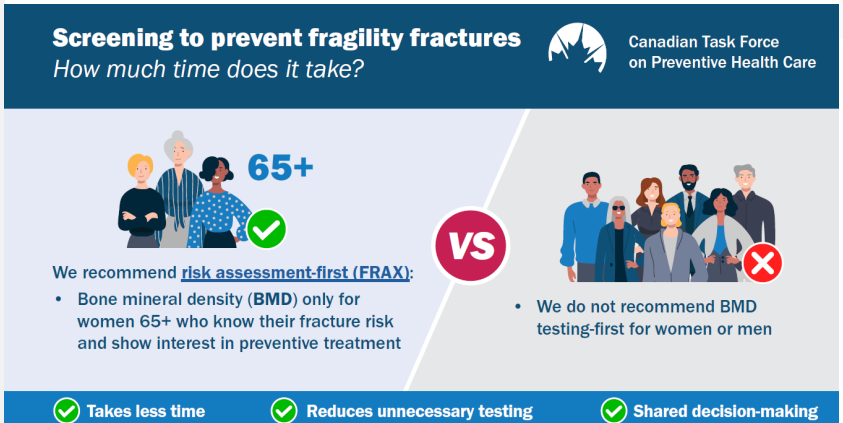
Canadian FRAX (without BMD) → Discuss with patient → *If preventive Rx therapy is being considered* → BMD → Add T-score into FRAX

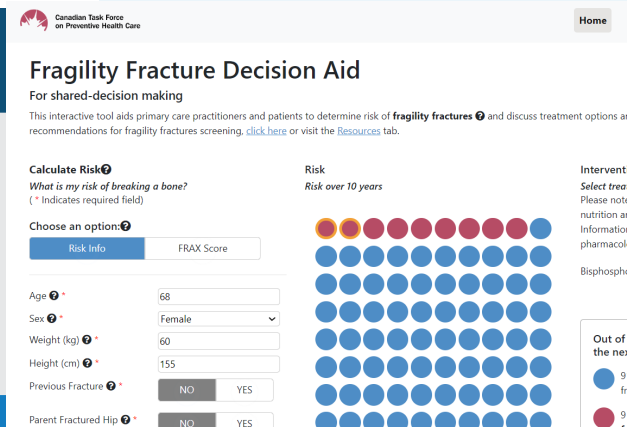
- Recommend against screening for females 40-64y, males ≥40y
- Re-screening frequency unknown; repeat BMD at 3-8y did not improve fracture risk prediction

Theriault et al. CMAJ 2023; 195: E639-49.

Bottom Line:

New Canadian guideline advocating risk-assessment first approach, followed by BMD for primary prevention of women >65y.





Does domperidone safely increase milk supply in breastfeeding mothers?

2018 SR[1] (5 RCT, n=192): moms of preterm infants

- Domperidone 10mg TID x5-14d vs placebo
- Mean ↑ expressed breast milk: 88ml/d over plb
- Maternal AE: no diff; infant AE: no diff/NR

Latest SRs[1,2]: similar (~90-95ml over plb; no AE)

Largest RCT, most useful from SR (n=90)

- 50% ↑ milk supply: 78% domperidone vs 58% placebo, NNT 5 over 14d
- Mean daily milk volume: 267ml domperidone vs 217ml (not SS, likely underpowered)
- BF rates (6 wks): no different

Safety: Obs study (n=45,518) domperidone w/in 6mo postpartum

- Hospitalization for ventricular arrhythmia per 10,000: 1.3 cases (domperidone) vs 0.5 cases (none); no difference
- If real, NNH 12,950

SR (6 case control studies), men >60y:

- Arrhythmia risk highest with doses >30mg/d (OR 3.3) vs ≤30mg (OR 1.6)

Context

- Small RCTs: no diff efficacy 30mg vs 60mg per day
- Low amounts enter breastmilk but infant AE similar placebo
- CI: if risk of arrhythmias
- Insufficient evidence on herbals

Bottom Line: In mothers of preterm infants, domperidone ↑milk volume by ~90ml more than placebo after 14 days. An additional 1 in 5 women experience 50% ↑in milk supply. Doses >30mg/d likely not needed, may increase arrhythmias. Optimal length of treatment unknown.

TFP #239 (July 2019), update: 2023. 1) Taylor 2019; J Hum Lactation 2019; 35(3); 501-9. 2) Shen 2021;

Fezolinetant for Hot Flashes

Four R, DB, PC trials: women with spontaneous or surgical menopause, ≥7 hot flashes/d, 12-week duration

	Dosing	Frequency of VMS	≥50% ↓ frequency VMS	Other notables
Depypere[1] 2019 (n=87)	90mg BID	*Baseline (weekly): 72-81* • 72-80 fewer with drug	--	• Severity scores: for 30mg/45mg doses, reduced scores by 8-12% • QOL: did not reach MCID[3,4,5] • Sleep disturbance: not req for entry, 45mg may help (e.g. "much improved": 15% placebo vs 28% (45mg), NNT 8) • No increase AE in 12 wk RCTs[1,2,4,5]
Fraser[2]/ Santoro[3] 2020 (n=356)	15-90mg BID, 30-120mg QD	*Baseline (daily): 9-11* • 2-3 fewer with drug	Placebo: 59% 30mg (n=43): 81% (NNT 4)	
SKYLIGHT-1[4] 2023 (n=527)	30mg QD 45mg QD	*Baseline (daily): 10-11* ↓ 4-5 fezo vs 7 placebo • 2-3 fewer with drug	Placebo: 30% 30mg: 45% (NNT 7) 45mg: 57% (NNT 4)	
SKYLIGHT-2[5] 2023 (n=500)	30mg QD 45mg QD	*Baseline (daily): 11-12* • 2-3 fewer with drug	Placebo: 43% 30mg: NSS 45mg: 61% (NNT 6)	

Bottom Line: For women with moderate-severe hot flashes, more women on fezolinentant have 50% reduction in hot flashes than placebo (45-60% vs 30-40%, NNT 4-7) over 12 weeks. Longer trials (52 weeks) are pending with side effect information.

1. J Clin Endocrinol Metab 2019;104: 5893-5905. 2. Menopause 2020; 27(4): 382-92. 3. Menopause 2020; 27(12): 1350-56. 4. Lancet 2023;401:1091-102. 5. J Clin Endocrinol Metab 2023;108:1981-1997.

Combined oral contraceptives during breastfeeding

RCTs from two SRs. OC started 2-6 weeks postpartum.

COC vs placebo

- EE 30mcg/LVN 0.15mg (n=182): at 90d postpartum, 6011g vs 6250g
- Mestranol 80mcg with progestin (n=50): at 2-5 weeks postpartum, weight gain ~7oz less vs placebo (no stats)
- Exclusive breastfeeding: at 90d, 81% vs 92%
- Supplemental formula: at 90d: 18% supplementing vs 8% plb, NSS; at 5 weeks, needing ~700 vs 190 (placebo) supplemental cal/week (no stats)

POP vs placebo, within 6 wks postpartum (two low-quality RCTs n=20, 400): no difference in infant growth

COC vs POP, largest RCT (n=171) 6-24w postpartum: No diff infant weight or supplementation; milk volume ↓ 42% (COC) vs 12%

- RCT 127 women: BF, AE no diff @ 6mo

Adverse effects (non-RCTs): no difference in growth/intellectual development over 8y or infant breast/genital changes at 1y

Bottom Line: Trials are older, small and highly unreliable. COCs may lower growth (by ~240g) and rates of exclusive breastfeeding (81% vs 92%) compared to placebo at 90d. POP evidence also unreliable: if real, infant growth is not different compared to placebo. Early postpartum contraception: progestin only recommended by guidelines due to increased VTE risk.

Pelvic floor exercises or pessaries for Stress Incontinence

PFMT vs no treatment/control (18 RCT, 26-133 women). At 6-24 weeks:

- Self-reported cure/improvement: 74% vs 11% control, NNT 2
- Leakage (baseline 1-2 episodes/d): reduced by 1 episode/d over control
- Satisfaction: 71% vs 13% control, NNT2
- Other SR and newer RCTs similar

Pessaries vs no treatment (n=55), after wks:

- Incontinence episodes: -32% vs -7.6% control
- Satisfaction: 60 versus 5 control

Pessaries vs PFMT (n=446), at 3 months:

- No bothersome symptoms: 49% vs 33% pessary, NNT 7
- Satisfaction: 54% vs 50% pessary, NNT 27
- At 12mo: No difference in efficacy; vaginal discharge (NNT 10)

Bottom Line: PFMT increases proportion with symptom improvement/cure (74% vs 11%) and satisfaction (71 vs 13%) compared to control over 1-6 months. Pessaries may reduce incontinence episodes compared to no treatment based on a small 2-wk study. Exercise may be slightly better than pessary at 3mo with less vaginal discharge at 12mo.

Can non-hormonal drugs improve vasomotor symptoms in menopause?

Meta-analyses, largest RCTs retrieved.

Hot flashes: baseline 9-11/d

- SSRI, gabapentin, desvenlafaxine: 1-2 fewer hot flashes over placebo at 4-12 wks
  - Example: 3-4 hot flashes vs 5-6 placebo
- Oxybutynin (n=148): 4 fewer over plb;
- Clonidine: no diff when breast cancer pts excluded

Proportion with ≥50% reduction hot flashes:

- 50-75% with gabapentin, desvenlafaxine, SSRI versus 35-60% on placebo (NNH 4-9)

"Much/very much improved" over 12 wks

- Gabapentin 58% vs 44% placebo, NNT 8
- Oxybutynin 73% vs 26% placebo, NNT 2

QOL: vs placebo

- Citalopram, fluox, sertraline: no diff
- Escitalopram: no clinical meaningful difference

Bottom Line: ~50-75% with hot flashes will have ≥50% decrease in hot flashes with SSRIs, SNRIs or gabapentin versus 35-60% on placebo over 12 weeks. Women receiving placebo experience ~40-50% reduction in hot flashes; those taking SSRI, SNRI, or gabapentin have a further 10-20% reduction.

#85. March 18, 2013; CFP 2013 May; 59: 503.

Should it stay or should it go?

1 SR, AJOG 2020

- Levonorgestrel (LNG) intrauterine device (IUD): 4 cohort studies, 2089 participants, looking at 52 mg device (Mirena®)
  - Years 6 & 7:
    - 0.02 pregnancies per 100 person-years (95% CI 0 – 0.29)
    - Expulsion rate ~0 to 1%
    - Infection rate 0-3%
    - Bleeding/pain leading to discontinuation 0.2 to 6.2%

- Copper-T380A IUD: 2 cohort studies, 473 participants
  - Current duration approved by Health Canada is ten years.[3]
  - Years 11 & 12:
    - No pregnancies reported (95% CI 0 – 0.8 pregnancies per 100-person-years)
    - Expulsion rate ~1%
    - No infections or perforations (reported in one study)
    - Bleeding/pain leading to discontinuation 1-5%

Bottom Line: If it is not possible or desirable to replace a levonorgestrel 52mg or copper-T380A intrauterine device (IUD) at the end of the approved duration of use, small observational studies demonstrated similar efficacy and safety for up to two additional years, with little evidence afterwards. Guidelines suggest that with patient-informed discussion, deferral of IUD replacement for up to twelve months is reasonable.

Endometrial Biopsy Evidence

SR, 1

- O

	LR +	LR -
	Increase probability	Decrease probability
Excellent	**>10**	**<0.1**
Good	**5-10**	**0.2-0.1**
Moderate/Small	2-5	0.2-0.5
Poor	1-2	0.5-1

7%–
tive test.

Bottom Line: Outpatient endometrial biopsy has a high overall accuracy in diagnosing endometrial cancer when an adequate specimen is obtained. In cases of abnormal uterine bleeding where symptoms persist despite negative biopsy, further evaluation is warranted.

BJOG 2003:109:3:313-321

Etonogestrel Implant (Nexplanon ®)

Info:

Approved in Canada since 2020 but used elsewhere for >10 years

Matchstick-sized flexible rod, bioequivalent to Implanon® but radio-opaque

Providers must complete specific training to insert

Indicated for 3 years but evidence suggests it stays effective for 5 years

Cost: $310 (compared to $370 for levonorgestrel IUDs which last at least 5 years)

Pearl Index (failure rate per 100 women in 1 year of exposure) = 0.0 - 0.34

Evidence:

Nexplanon vs. Lev-IUD (Jaydess® - no longer available), 766 women, over 12 months

- 0 pregnancies with implant vs. 3 with Lev-IUD
- Discontinuation at 12 months: 27% with implant versus 20% with IUD (p=0.0092)
- bleeding: 11.3% with the implant versus 3.2%
- Amenorrhea more frequent with the implant (29% vs 9%), but more women had prolonged bleeding (16% versus 5%) and only 4% had a normal bleeding pattern (versus 31% with the IUD)

Bottom Line: The etonogestrel implant (Nexplanon) is an effective, long-acting, reversible contraception (LARC). Further studies comparing Nexplanon to other more commonly prescribed forms of LARC are required.

TFP #315, May 2022.

Mama needs a Java

Cohort study, 2055 women (mean age 28.3 years, mean BMI 23.6). Plasma caffeine level ≤28 ng/mL vs. >659 ng/mL:

- Lower birth weight by 84.3 g (95% CI, -145.9 to -22.6 g)
- Shorter length by 0.44 cm (95% CI, -0.78 to -0.12 cm)
- Smaller head, arm and thigh circumference by ~0.3cm

Women who reported drinking no caffeinated beverages vs. women who consumed about 50mg/day (½ cup of coffee)

- Lower birth weight by 66g (95% CI, -121 to -10 g)
- Smaller arm, thigh circumference and smaller anterior flank skin fold by ~0.2 - 0.3 cm)

JAMA Netw Open. 2021;4(3):e213238.

Mama needs a Java

RCT 1207 women, <20 weeks GA, ≥3 cups coffee/day
Regular vs. decaffeinated coffee
Results:

- Mean caffeine 317mg vs. 117mg
- No difference: mean birth weight (3539g vs 3519g), length of gestation (279d vs 280d)
- Limitations: Unknown compliance, 49% guessed in noncaffeinated group, questionnaire, only 2nd half of pregnancy

Bottom Line: While some cohort studies have shown a correlation between lower birth rates and caffeine intake during pregnancy, this is not as pronounced in RCT-level evidence suggesting there could be confounding variables not accounted for in observational data. As with most things, moderation is likely important.

BMJ 2007;334:409

Antibiotic prophylaxis in operative deliveries

Publicly funded, multicentre, blinded RCT, 3427 women (mean age of 30 years); forceps or vacuum delivery at ≥ 36 weeks - randomized to a single dose of IV amoxicillin− clavulanic acid (1 g and 200 mg) or IV saline within 6 hours of delivery:

- reduced rate of maternal infection (11% vs 19% saline) – NNT 13
- less perineal pain (46% vs 55% saline)
- less wound breakdown (11% vs 21% saline)
- less primary care visits for perineal issues (28% vs 38% saline)
- cost savings of ~$93/patient in the antibiotic group

Bottom Line: A single dose of intravenous amoxicillin and clavulanic acid given within 6 hours after operative (vacuum- or forceps-assisted) birth reduces maternal infections, perineal problems, health care visits, and costs.

Lancet 2019;**393**(10189):2395-403

Ms. Independant

3,973 women (with and without symptoms) in sexual health centre had self-collected vaginal swab (SCVS) followed by physician endocervical swab:

- Sensitivity
  - Chlamydia: 97% SCVS vs. 88%
  - Gonorrhea: 99% SCVS vs. 96%

1,464 symptomatic and asymptomatic women at primary/secondary care clinics, all collected SCVS, physician vaginal, or endocervical swabs and first catch urine (FCU):

- Physician and SCVS: Similar sensitivity (>95%) for gonorrhea and chlamydia.
- SCVS versus FCU: SCVS identified statistically significantly more patients with chlamydia (196 versus 171)

Systematic review (21 studies) reported no difference in sensitivity of FCU (87%) versus SCVS (92%)

- Patients find SCVS "easy" to perform (88%) and prefer home completion.8
- Patients randomized to home testing (swabs mailed to their home) are twice as likely to complete the test (~60% versus 30%)

Bottom Line: Self-collected vaginal swabs (SCVS) appear more sensitive in diagnosing chlamydia and gonorrhea than health professional collected endocervical swabs and first catch urine (FCU). Endocervical swabs and FCU testing may miss up to 10% of STIs in women. SCVS (when pelvic exam not required) is recommended in women and FCU in men.

Can we dampen the crampin'?

Misoprostol (oral or intravaginal): 3 systematic reviews[1,2] (3-11 RCTs, 342-1485 participants)

- No improvement in pain over placebo
- Reduced moderate to severe pain in 1 RCT1 (37% versus 67% [placebo])
- Cramping pre-insertion (53% versus 33% [placebo])[1]

NSAIDs: 2 systematic reviews1,2 (2-7 RCTs, 155-2577 participants):

- no difference on pain except for one RCT (pain score 2.9 versus 4.9 [placebo])[4]

Others: No effect over placebo seen with inhaled nitric oxide, topical nitroprusside or topical nitroglycerin[1,2]

1) Lopez et al. Cochrane Database SystRev. 2015; 7 : CD007373. 2) Pergiolatis et al. Eur J Contracept Reprod Health Care. 2014; 19(3): 149-60. 3) Karabayirli S, et al. J Minim Invasive Gynecol. 2012; 19(5): 581-4.

Can we dampen the crampin'?

Lidocaine:

- **Topical lidocaine** applied 1-5 minutes pre-procedure: 3 SRs[1,2,3] (2-9 RCTs, 345 – 1899 participants)
  - No effect versus placebo (1-2% gel or cream)
  - 1 RCT (4% gel) pain score 2.8 versus 4.4 (placebo)[1]
- **Paracervical lidocaine 1% block**: 2 SRs [2,3] (2-4 RCTs, 114 - 310 participants)
  - Most comprehensive review shows no benefit[8]
- **Topical lidocaine-prilocaine** (EMLA®) applied to cervix and cervical os 7 minutes pre-procedure: 2 SRs [1,3] (1-2 RCTs, 114 to 212 patients)
  - 2-3 points over placebo
- **Lidocaine spray** (4 puffs at 10mg/puff) to cervix 3 minutes pre-procedure (3 RCTs, 124 to 200 patients) [4-6]
  - 2 points lower than placebo
  - More effective than lidocaine cream in direct comparison RCT[10]

Context:

- No guideline consensus
- Mean insertion pain is ~4-5/10 in placebo groups, limiting analgesic potential

Bottom Line: Topical lidocaine-prilocaine (EMLA®) or lidocaine spray decrease IUD insertion pain by 2-3 points compared to placebo on an 11-point scale Other interventions show inconsistent evidence or no benefit over placebo.

1) Cochrane Database SystRev. 2015; 7 : CD007373. 2) Eur J Contracept Reprod Health Care. 2014; 19(3): 149-60. 3) Eur J Contracept Reprod Health Care. 2018; 23(3) : 207-17. 4) J Fam Plann Reprod Helath Care. 2016; 42(2): 83-7. 5)J Obstet Gynaecol Res 2017 June; 43 (6): 1061–6. 6) BMJ Sex Reprod Health. 2021; 47: 159-165

Removing the speculum in cervical cancer screening

Landy R, Hollingworth T, Waller J, et al. Br J Gen Pract. 2021; Dec 31;72(714):e26-33.

Bottom Line: **In women not being regularly screened, providing non-speculum and self-sampling options significantly increases uptake of cervical cancer screening at 4 and 12 months. System changes will be required to bypass cytology and allow for direct access to lab services.**

RCT: 784 women (50-64 y.o. and last screened 6-15 years ago) randomized to intervention (choice of clinician non-speculum, clinician speculum, or self-sample) or usual care (reminder letter sent to all women in England every 5 years)

- All HPV+ pts received a follow-up letter for standard (speculum) testing

Results:

Uptake at 4 months: **20%** versus **5%** control (statistically significant)

Uptake at 12 months: **31%** versus **14%** (statistically significant)

What women chose: 23% non-speculum clinician sample, 36% self-sample, 42% speculum sample

4 HPV+ (70 samples): two non-speculum clinician samples had abnormal cytology (normal hx on biopsy) and two self-samples had negative cytology.

Is that cabbage in your bra?

TFP #209

Bottom Line: **Women report higher levels of satisfaction with cabbage leaves than either routine care or cold gel packs (with an extra 1 in 4 and 1 in 6 reporting satisfaction, respectively). Cabbage leaves reduce pain by ~1/10 and hardness by ~0.4/6 associated with breast engorgement compared to usual care. Cabbage leaves likely do not need to be chilled.**

Results: 226 breastfeeding mothers with engorgement compar
routine care (education by lactation consultant)

- Routine Care: Cabbage decreased pain at 30 minutes, 1 and 2 hour
  hardness by 0.2-0.4 on 6-point scale.
- Satisfaction: women were more satisfied or highly satisfied with ca
  or gel packs (81%); NNT 4-6

New SR (2023)- No change in evidence; small reduction in breast pain.

Context:

One RCT found no difference between chilled/room temperature cabbage

Other treatments including hot/cold packs, acupuncture, and acupressure are poorly studied.

Cabbage leaves are inexpensive, widely available and the appropriate shape.

Speculate on the Speculum: Pain Free Pap Endings

Yen NK et al. Pain 2023. Apr 12.

Bottom Line

Adding 15 seconds before speculum removal may decrease pain for women by about 1-point on an 11-point scale and increase willingness to receive future Pap smears.

1-year RCT conducted in Taiwan

- 266 women (mean age 53, 94% previous Pap, predicting 3/10 pain) randomized to modified Pap(adding 15-second lag between rotating speculum and removal) or traditional Pap

5-minute pain recall (0-10 VAS): 2.12 versus 3.13 (traditional); Mean Difference (MD) -1.01; $p<0.001$

- At one year: 1.81 versus 3.69 (traditional); $p<0.001$

Willingness to receive future Pap (0-10; higher=more willing) @ 1 year: 7.73 versus 5.68 (traditional); MD 2.04; $p<0.001$

Pregnant and Puking: What's the evidence for N/V in Pregnancy?

TFP #153, #186, #192

	Efficacy	Harms	Considerations
Doxylamine/ B6 (Diclectin)	~1-point better than placebo on 15-pt N/V scale B6: ~25% reduction over placebo.	Drowsiness 5.6% v 3% NNH 38	++ Conflicts of Interest
Ondansetron **NNT 2-3**	25% symptom reduction: Nausea 92% vs 41% (dox/B6) Vomiting: 77% vs. 35% (dox/B6) *Used ½ dose doxylamine.	Malformation (cohort) 4.7% versus 3.5% (5 other cohorts- no increased risk) Cardiac- highest quality no increased risk	Many limitations with harms data. More evidence required.
Ginger	First trimester: ~4 on 40-pt N/V scale. Stop vomiting **NNT 3** (at 6 days) No diff vs Diclectin (1 RCT, n=63)	Largest cohort- no increase in malformation/stillbirth. Vaginal bleeding/spotting after 17 weeks: 7.8% vs 5.8%	Dose ~1 g/d divided BID to QID. Considered contraindicated close to labour. OTC

Rule out and treat other dietary/vitamin causes.
Consider B6 or diclectin +/- ginger.
Consider ondansetron for moderate/severe nausea.

How to Slow the Flow: Options for Heavy Menstrual Bleeding

TFP #287, #323, #348

Population: Premenopausal women with heavy menstrual bleeding due to benign etiology.

	Blood Loss	Sanitary Products	Satisfaction	Remaining on Tx
NSAIDs	~30%	~20-50%	NR	NR
IUDs	~80%	NR	75%	64%
Tranexamic Acid	~40%	5-10 fewer/cycle	NR	NR

Across all treatments: volume of blood loss does not correlate with patient experience.

How to Slow the Flow: Options for Heavy Menstrual Bleeding

TFP #287, #323, #348

Population: Premenopausal women with heavy menstrual bleeding due to benign etiology.

	Cost	Other Considerations
NSAIDs	$20/cycle $4/cycle	Used immediately before and during menses. Inconsistent evidence on effects on bleeding duration. Aes: GI, gastritis, dyspepsia, peptic ulcers, edema, etc.
IUDs	Upfront cost $350-$400/5 yrs	Irregular bleeding/spotting, especially in first 3-6 mos. 20-80% ammenorrhic at 1 year Provides reliable contraception
Tranexamic Acid	$14/cycle	Adverse events similar to placebo in included RCTs AEs in other literature: headache, GI Pain, N/V/D Avoid with thromboembolic history.

From A to O: Tackling Sexual Desire in Premenopausal Women

Yen NK et al. Pain 2023. Apr 12.

Hypoactive sexual desire disorder (HSDD)

- Most common form of sexual dysfunction in women.
- Characterized by persistent low sexual desire and associated distress.

	Benefit	Harms	Considerations
Flibanserin "Addyi" 4 Trials; 4497 women	~7% improvement in desire. 0.4-1.0 additional "satisfying" sexual events/month	Dizziness/Somnolence **NNH 10-15** Risk of syncope/hypotension, particularly with alcohol use.	100 mg oral @ hs Only approved medication in Canada for HSDD. **~$300/month**
Bremelanotide "Vyleesi" FDA-Approved 2 Trials; 1267 women	Perceived benefit: 58% vs. 36% (placebo) **NNT 5** No difference in satisfying sexual events.	Flushing (20%), Headache (10%) vs placebo (<2%) Nausea 40% vs 1.3 **NNH 3** Onset- 30 minutes after dose; duration 2.4 hours	1.75 SC ~45 minutes before sexual activity (max 8 doses/month) Rare: ↑BP (<2%), focal hyperpigmentation (1%)