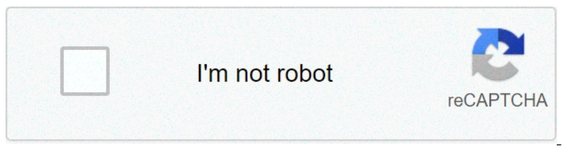

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Ovuloc ld tablet uses in tamil

Plot No. 29-33, Ancillary Industrial Plots, Govandi, Mumbai - 400 043. Generic name: ethinyl estradiol and desogestrel (EH thih nill ess tra DYE ole and des oh JESS trel)Brand name: Apri, Azurette, Bekyree, Caziant, Cyred, Emoquette, Enskyce, Isibloom, Juleber, Kalliga, Kariva, Mircette, Pimtrea, Reclipsen, Simliya, Velivet, Viorele, Volnea, ...show all 25 brand namesDesogen, Ortho-Cept, Cyclessa, Solia, Cesia, Kimidess, Cyred EQDosage forms: oral tablet (0.15 mg-0.03 mg; biphasic; triphasic 25 mcg)Drug class: Contraceptives Medically reviewed by Drugs.com on Feb 24, 2020. Written by Cerner Multum. What is ethinyl estradiol and desogestrel? Ethinyl estradiol and desogestrel is a combination birth control pill containing female hormones that prevent ovulation (the release of an egg from an ovary). ethinyl estradiol and desogestrel also causes changes in your cervical mucus and uterine lining, making it harder for sperm to reach the uterus and harder for a fertilized egg to attach to the uterus. Ethinyl estradiol and desogestrel is used to prevent pregnancy. There are many brands of this medicine available. Not all brands are listed on this leaflet. Ethinyl estradiol and desogestrel may also be used for purposes not listed in this medication guide. Do not use birth control pills if you are pregnant or if you have recently had a baby. You should not use birth control pills if you have: uncontrolled high blood pressure, heart disease, coronary artery disease, circulation problems (especially with diabetes), undiagnosed vaginal bleeding, liver disease or liver cancer, severe migraine headaches, if you also take certain hepatitis C medication, if you will have major surgery, if you smoke and are over 35, or if you have ever had a heart attack, a stroke, a blood clot, jaundice caused by pregnancy or birth control pills, or cancer of the breast, uterus/cervix, or vagina. Taking birth control pills can increase your risk of blood clots, stroke, or heart attack. Smoking can greatly increase your risk of blood clots, stroke, or heart attack. You should not take birth control pills if you smoke and are over 35 years old. Taking birth control pills can increase your risk of blood clots, stroke, or heart attack. You are even more at risk if you have high blood pressure, diabetes, high cholesterol, or if you are overweight. Your risk of stroke or blood clot is highest during your first year of taking birth control pills. Your risk is also high when you restart birth control pills after not taking them for 4 weeks or longer. Smoking can greatly increase your risk of blood clots, stroke, or heart attack. Your risk increases the older you are and the more you smoke. You should not take combination birth control pills if you smoke and are over 35 years old. Do not use if you are pregnant. Stop using ethinyl estradiol and desogestrel and tell your doctor right away if you become pregnant, or if you miss two menstrual periods in a row. If you have recently had a baby, wait at least 4 weeks before taking birth control pills. You should not take birth control pills if you have: untreated or uncontrolled high blood pressure; heart disease (chest pain, coronary artery disease, history of heart attack, stroke, or blood clot); an increased risk of having blood clots due to a heart problem or a hereditary blood disorder; circulation problems (especially if caused by diabetes); a history of hormone-related cancer, or cancer of the breast, uterus/cervix, or vagina; unusual vaginal bleeding that has not been checked by a doctor; liver disease or liver cancer; severe migraine headaches (with aura, numbness, weakness, or vision changes), especially if you are older than 35; a history of jaundice caused by pregnancy or birth control pills; if you smoke and are over 35 years old; or if you take any hepatitis C medication containing ombitasvir/paritaprevir/ritonavir (Technivie). To make sure birth control pills are safe for you, tell your doctor if you have ever had: heart disease, high blood pressure, or if you are prone to having blood clots; varicose veins; high cholesterol or triglycerides, or if you are overweight; depression; migraine headaches; diabetes, gallbladder disease; liver or kidney disease; irregular menstrual cycles; or fibrocystic breast disease, lumps, nodules, or an abnormal mammogram. The hormones in birth control pills can pass into breast milk and may harm a nursing baby. This medicine may also slow breast milk production. Do not use if you are breast feeding a baby. Follow all directions on your prescription label. Do not take this medicine in larger or smaller amounts or for longer than recommended. You will take your first pill on the first day of your period or on the first Sunday after your period begins. You may need to use back-up birth control, such as condoms or a spermicide, when you first start using this medicine. Follow your doctor's instructions. Take one pill every day, no more than 24 hours apart. When the pills run out, start a new pack the following day. You may get pregnant if you do not take one pill daily. Get your prescription refilled before you run out of pills completely. Some birth control packs contain seven "reminder" pills to keep you on your regular cycle. Your period will usually begin while you are using these reminder pills. You may have breakthrough bleeding, especially during the first 3 months. Tell your doctor if this bleeding continues or is very heavy. Use a back-up birth control if you are sick with severe vomiting or diarrhea. If you need major surgery or will be on long-term bed rest, you may need to stop using this medicine for a short time. Any doctor or surgeon who treats you should know that you are using birth control pills. While taking birth control pills, you will need to visit your doctor regularly. Store at room temperature away from moisture and heat. Follow the patient instructions provided with your medicine. Ask your doctor or pharmacist if you do not understand these instructions. Missing a pill increases your risk of becoming pregnant. If you miss one active pill, take two pills on the day you remember. Then take one pill per day for the rest of the pack. If you miss two active pills in a row in Week 1 or 2, take two pills per day for two days in a row. Then take one pill per day for the rest of the pack. Use back-up birth control for at least 7 days following the missed pills. If you miss two active pills in a row in Week 3, throw out the rest of the pack and start a new pack the same day if you are a Day 1 starter. If you are a Sunday starter, keep taking a pill every day until Sunday. On Sunday, throw out the rest of the pack and start a new pack that day. If you miss three active pills in a row in Week 1, 2, or 3, throw out the rest of the pack and start a new pack on the same day if you are a Day 1 starter. If you are a Sunday starter, keep taking a pill every day until Sunday. On Sunday, throw out the rest of the pack and start a new pack that day. If you miss two or more pills, you may not have a period during the month. If you miss a period for two months in a row, call your doctor because you might be pregnant. If you miss a reminder pill, throw it away and keep taking one reminder pill per day until the pack is empty. Seek emergency medical attention or call the Poison Help line at 1-800-222-1222. Overdose symptoms may include nausea, vomiting, and vaginal bleeding. Do not smoke while taking birth control pills, especially if you are older than 35 years of age. Birth control pills will not protect you from sexually transmitted diseases--including HIV and AIDS. Using a condom is the only way to protect yourself from these diseases. Get emergency medical help if you have signs of an allergic reaction: hives; difficult breathing; swelling of your face, lips, tongue, or throat. Stop using birth control pills and call your doctor at once if you have: signs of a stroke--sudden numbness or weakness (especially on one side of the body), sudden severe headache, slurred speech, problems with vision or balance; signs of a blood clot--sudden vision loss, stabbing chest pain, feeling short of breath, coughing up blood, pain or warmth in one or both legs; heart attack symptoms--chest pain or pressure, pain spreading to your jaw or shoulder, nausea, sweating; liver problems--loss of appetite, upper stomach pain, tiredness, fever, dark urine, clay-colored stools, jaundice (yellowing of the skin or eyes); increased blood pressure--severe headache, blurred vision, pounding in your neck or ears; swelling in your hands, ankles, or feet; changes in the pattern or severity of migraine headaches; a breast lump; or symptoms of depression--sleep problems, weakness, tired feeling, mood changes. Common side effects may include: nausea, vomiting (especially when you first start taking ethinyl estradiol and desogestrel); breast tenderness; breakthrough bleeding; acne, darkening of facial skin; weight gain; or problems with contact lenses. This is not a complete list of side effects and others may occur. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088. Usual Adult Dose for Contraception:0.15 mg desogestrel/0.03 mg ethinyl estradiol tablet regimen:-Days 1 to 21: 1 tablet orally once a day-Days 22 to 28: 1 inert tablet orally once a dayBiphasic regimen:-Days 1 to 21: 0.15 mg desogestrel/0.02 mg ethinyl estradiol tablet orally once a day-Days 22 to 23: 1 inert tablet orally once a day-Days 24 to 28: 0.01 mg ethinyl estradiol tablet orally once a dayTriphasic regimen:-Days 1 to 7: 0.1 mg desogestrel/0.025 mg ethinyl estradiol tablet orally once a day-Days 8 to 14: 0.125 mg desogestrel/0.025 mg ethinyl estradiol tablet orally once a day-Days 15 to 21: 0.15 mg desogestrel/0.025 mg ethinyl estradiol tablet orally once a day-Days 22 to 28: 1 inert tablet orally once a dayComments:-This drug should be taken at the same time each day.-Patients may begin on the first day of the menstrual period or on the first Sunday after the onset of the menstrual period.-Additional forms of contraception should be used if patients begin on Sunday.Use: Prevention of pregnancyUsual Pediatric Dose for Contraception:Postpubertal adolescents:0.15 mg desogestrel/0.03 mg ethinyl estradiol tablet regimen:-Days 1 to 21: 1 tablet orally once a day-Days 22 to 28: 1 inert tablet orally once a dayBiphasic regimen:-Days 1 to 21: 0.15 mg desogestrel/0.02 mg ethinyl estradiol tablet orally once a day-Days 22 to 23: 1 inert tablet orally once a day-Days 24 to 28: 0.01 mg ethinyl estradiol tablet orally once a dayTriphasic regimen:-Days 1 to 7: 0.1 mg desogestrel/0.025 mg ethinyl estradiol tablet orally once a day-Days 8 to 14: 0.125 mg desogestrel/0.025 mg ethinyl estradiol tablet orally once a day-Days 15 to 21: 0.15 mg desogestrel/0.025 mg ethinyl estradiol tablet orally once a day-Days 22 to 28: 1 inert tablet orally once a dayComments:-This drug should be taken at the same time each day.-Patients may begin on the first day of the menstrual period or on the first Sunday after the onset of the menstrual period.-Additional forms of contraception should be used if patients begin on Sunday.Use: Prevention of pregnancy What other drugs will affect birth control pills? Other drugs may interact with birth control pills, including prescription and over-the-counter medicines, vitamins, and herbal products. Some drugs can make birth control pills less effective, which may result in pregnancy. Tell your doctor about all your current medicines and any medicine you start or stop using. Remember, keep this and all other medicines out of the reach of children, never share your medicines with others, and use this medication only for the indication prescribed.Always consult your healthcare provider to ensure the information displayed on this page applies to your personal circumstances. Medical Disclaimer Copyright 1996-2021 Cerner Multum, Inc. Version: 11.03. GETTYBeryl's only option was to have a hysterectomyBeryl Romain, from Ealing, carried an 18 inch fibroid for years. The condition caused her to look heavily pregnant. When she was initially diagnosed with fibroids, Beryl was engaged and about to study journalism. However, after being told that the only treatment option was a hysterectomy, Beryl’s fiancée left her because she couldn’t have children and she had to give up her hopes of becoming a journalist.Last year, Beryl had a hysterectomy at Guy’s Hospital, a surgery she was keen to avoid. NHS Choices said the exact cause of fibroids is unknown but they are linked to the hormone oestrogen - the female reproductive hormone. GETTYBefore the tablet was introduced, one of the only options for women was surgeryThe website said: “Fibroids are thought to develop more frequently in women of African- Caribbean origin. “It's also thought they occur more often in overweight or obese women because being overweight increases the level of oestrogen in the body.“Women who've had children have a lower risk of developing fibroids, and the risk decreases further the more children you have.“Fibroids can grow anywhere in the womb and vary in size considerably. Some can be the size of a pea, whereas others can be the size of a melon.Do you know the symptoms of gynaecological cancers? Treatment of patients with ovulation problems that are causing menstrual problems will depend on whether the patient wishes to become pregnant or not. Prior to beginning treatment, it is important that the patient is adequately investigated to define the exact cause of the ovulation problem and menstrual disturbance. In the great majority of cases it should be possible to tell patients why their ovaries are not working properly and why they have some menstrual disturbance. PCOS treatment options If the patient does not wish to become pregnant No treatment If the patient has been thoroughly investigated and understands the cause of her ovulation problem and her absent or deficient periods then no treatment is one option. This means if the patient can continue to have no periods or infrequent periods. There are however two problems with this option. If no treatment is given the patient will not have any contraception. Patients who do not wish to become pregnant but are sexually active can therefore become pregnant even though their periods may be infrequent or absent. Patients in this situation often have times of great anxiety when they have been sexually active but are not having any periods. They may be constantly concerned about whether they are pregnant or not. In patients with no periods, it must be remembered that the ovary is not working properly and is not providing the full quota of the female hormone, oestrogen. Therefore many patients with ovulation disorders and infrequent or absent periods are hormonally deficient for much of the time. This hormonal deficiency is like that of a menopausal lady. This means that patients may be prone to increasing de-mineralisation and weakening of their bones as well as exposing themselves to an increased risk of heart attack and stroke. There is therefore an argument for hormone replacement therapy in women where their ovaries are working poorly. If hormone replacement is given the hormone deficiency status is reversed. They may feel and function better, have better intercourse and avoid the risks of pregnancy as discussed. For patients who are overweight with PCOS, weight loss by 5-10% is a proven treatment that might reverse the condition. Weight management is very important for patients with PCOS and will improve ovulation, periods and will reduce long-term diabetes risk. Oral contraceptive pill Patients who are not having any or many periods and who have been adequately investigated but do not wish to become pregnant may be put on the oral contraceptive pill. The advantages of this treatment are: Contraception is provided Regular bleeds occur (although these are not true periods but hormone withdrawal bleeds) Hormone replacement therapy is achieved Anxiety about unwanted pregnancies is reduced The pill provides a cheap and convenient form hormone therapy The lining of the uterus is controlled and the development of serious abnormalities in the lining of the uterus are often avoided Almost any of the commercially available oral contraceptive agents can be used. The usual side effects and risks of the oral contraceptives may occur. For patients with PCOS the oral contraceptive of choice is called Diane-35. It contains 35 micrograms oestrogen (ethinyloestradiol) which is the most common oestrogen used in nearly all the oral contraceptive pills. This is slightly more than some of the ultra low-dose pills on the market which may contain only 30 micrograms of oestrogen. However it is still a lower dose pill than many other commercially available oral contraceptives which may contain up to 50 micrograms of oestrogen. What makes Diane-35 special is the progesterone agent. Nearly all oral contraceptive pills contain two components. These combined oral contraceptives contain oestrogen and a progesterone agent. The progesterone agent used in Diane-35 is cyproterone acetate. This has rather special properties in that it is an anti-male hormone. Cyproterone acetate reduces the conversion of testosterone to its more active forms in areas of the body such as the skin. Diane-35 therefore has the ability to reverse the action of excessive or too active male hormone and reduce problems such as acne and abnormal hair growth. Diane-35 is therefore the oral contraceptive pill of choice for patients with PCOS or patients who have evidence of excessive male hormone activity such as acne or excessive hair growth. It comes in a packet with 21 active pills and 7 sugar pills. It has the usual risks and side effects of any oral contraceptive pill. In Australia it is not available on Medicare and is therefore slightly more expensive than the ordinary pill. Patients with PCOS can sometimes claim the costs from their health funds in view of their medical condition. Other hormonal treatments for PCOS or ovulation problems. It is not necessary to only use the oral contraceptive pill. Patients can have hormone therapy protocols made for them using either oestrogen and progesterone or progesterone alone. Various commercially available progesterones can be used such as Norethisterone (Primolut-N), Medroxyprogesterone (Provera) and the mini-pill preparations. These can be used to regulate cycles and produce more regular and controlled periods. Their place however is quite limited and they are not often used. A special sort of ovulation disturbance caused by pituitary tumour called a prolactinoma has been previously discussed. The treatment of choice for this condition is a drug called Bromocriptine or a newer one called Dostinex. If the patient does wish to become pregnant Patients with disordered ovulation who wish to become pregnant can have treatment with a number of hormones which will induce ovulation. The success rates with these treatments are very high. Ovulation defects are the most successfully treated area of infertility. Agents used to induce ovulation: GnRH As previously explained GnRH is the messenger hormone, which travels from the higher centres of the brain to the pituitary gland. It is possible to administer GnRH in small continuous doses via a syringe pump. This pump is normally attached to the patient’s arm, leg or abdomen and connected to a needle which is permanently left in place. In this way small continuous doses of GnRH are pumped into the blood stream. These can then go to the pituitary gland and encourage it in turn to send messenger hormone (FSH and LH) to the ovary. In practice GnRH is very rarely or never used, because: It is expensive The doses are complex The patient needs a permanently inserted needle attached to a syringe pump for 7 to 14 days It is often easier to use other agents such as clomiphene or give injections of FSH and LH which will go directly to the ovary than indirectly attempt to influence the ovary through the pituitary. Clomiphene Citrate (Serophene or Clomid) This is one of the oldest ovulation induction agents available. It is a steroid-like substance that binds to oestrogen receptors. Oestrogen receptors are protein sites in the body, which bind the female hormone oestrogen and then trigger the response to oestrogen in the individual cells and tissues of the body. It is only through these receptor sites that the hormones can exert their influences throughout the body. When clomiphene binds to oestrogen receptor sites in the pituitary gland in the brain it prevents the pituitary gland receiving any oestrogen messages from the ovary. The pituitary gland is then dummied into believing that the ovary is not working and therefore proceeds to pump out more FSH to tell the ovary to work harder. This FSH travels to the ovary and induces egg growth and development. Serophene/Clomid comes as 50 mg tablets. The normal dose is a half to one tablet per day for five days but up to three tablets per day for five days can be given. If a patient is having disturbed ovulation with roughly 28-day cycles it would normally be given from Day 4 to Day 8 or Day 5 to Day 9 of the cycle. In patients who do not have periods (or only have them infrequently) it can be given for five days. Ovulation usually occurs five to eight days after the last tablet. It is best to combine treatment with some monitoring of the cycle to assess how well the Clomid has worked and to define the time of egg release. Patients can have daily blood tests which begin usually about five days after the last tablet. These blood tests can predict the time of egg release to optimally time intercourse or artificial insemination. Monitoring will double pregnancy rates per treatment cycle to about 8% per cycle. Clomid tablets and “best given” intercourse has a 4% pregnancy rate per month. Side effects of Serophene/Clomid relate mainly to the fact that it blocks the action of the female hormone oestrogen. The patient may get a dry vagina, mood changes, hot flushes, headaches and breast discomfort. These side effects are often minor and will disappear near ovulation. The multiple pregnancy risk has been quoted at 4 to 8% of all pregnancies. Clomid is a relatively weak fertility agent and is rarely associated with high-order multiple pregnancies. Quadruplets and triplets have been reported after treatment but the majority of multiple pregnancies are twins. Serophene/Clomid works best in patients who have minor disorders of ovulation. In these patients it will induce ovulation 60 to 70% of cases with total pregnancy rates of up to 50%. In patients who have more severe ovulatory disturbance, such as absent or very infrequent periods, the response will be much less. Ovulation will only be induced in 30 to 40% of patients and pregnancy rates are usually in the order of 25 to 30%. Many of these patients will need more sophisticated treatment than Serophene/Clomid provides. The advantages of Serophene/Clomid therapy are: It is cheap It is simple to take 5 or 10 tablets over 5 days It is convenient It has a low incidence of side effects It has a low incidence of multiple pregnancies It does not require complex or sophisticated monitoring FSH FSH is the hormone which travels from the pituitary gland to the ovary, telling the ovary to grow and mature eggs each month. FSH is available in ampoules. Each ampoule has a dose of 75 or 150 units. Treatment with FSH is the most powerful and reliable treatment for patients with ovulation disorders. Pregnancy rates of up to 15% per treatment cycle can be expected. The overall pregnancy rate for patients who need and use this treatment is in the order of 60% per patient. Unlike Clomid, the more serious the ovulation disturbance, the more likely FSH is to work. The aim of giving FSH treatment is to mimic the normal egg development during the menstrual cycle. FSH injections are therefore given each morning as an intramuscular injection. It is best to start with the lowest dose of FSH per day (using 75 units per day). These doses are used for 4 to 6 days at a time. The ovarian response is determined by measuring oestrogen levels in the blood. When the oestrogen begins to rise, the FSH is successfully growing an egg or eggs. If there is no response to a dose of FSH in 5-6 days of injections the dose will be increased. The normal dose increments are 75 units, 112 units, 150 units and 225 units per day. Most patients respond with 75 to 150 units per day. However it is very important that increments are only made cautiously. The ovary is very sensitive to FSH dosage and too much FSH rapidly grows multiple eggs. It is important that patients receiving FSH therapy start with the lowest possible dose and the increments in the dose are only made gradually after a trial of a particular dose for at least five to seven days. When the blood levels of oestrogen rise to a point consistent with the mature egg an ultrasound scan will be done. The size and number of follicles (egg containing cysts) growing on the ovary can be measured. Follicle sizes of 14 to 20 mm usually indicate a mature egg. It is important to know the number of follicles present to minimise the risk of a multiple pregnancy. If conditions are favourable, release of the egg is then initiated. The egg is released by giving an injection of hormone called Human Chorionic Gonadotrophin (HCG). HCG is a natural pregnancy hormone. It has a structure almost identical to LH and can therefore be used to trigger egg maturation and release. A dose of 2,000-5,000 units of HCG is given as an intramuscular injection. Egg release will occur 36 to 44 hours later. The HCG injection is therefore given 1½ to 2 days prior to intercourse or insemination. HCG is also used to provide support to the ovary in the second half of the cycle after ovulation has occurred. As the first half of the cycle has been artificially created with FSH injections it is important to support the second half of the cycle. If this is not done there will be insufficient progesterone production and the pregnancy will find it very hard to implant as the corpus luteum undergoes premature degeneration. HCG injections 3 days and 7 days after ovulation will prevent this and provide appropriate early pregnancy support. Side effects of FSH treatment are few. FSH is a natural hormone and apart from the inconvenience of a daily injection has little side effects. The major risks of FSH therapy are those of multiple pregnancy and overstimulation. Multiple pregnancy rates are up to 20% of all pregnancies produced by this treatment. If FSH treatment is not strictly controlled it is treatment with this ovulation drug which causes high order multiple pregnancies such as quins and sextuplets. The combination of oestrogen levels and ultrasound scan should be used to assess the likely number of eggs being released by the HCG injection. If more than two or three eggs are likely to be released, cancellation should be discussed with the patient. It is very difficult in some patients, especially those with PCOS to choose the correct dose of FSH. If too little FSH dosage is used then no eggs grow. If the dose is increased only a very small amount sometimes many eggs grow on the ovary, often as many as 15 or 20. In some patients with PCOS there is no correct dose. Some patients with PCOS therefore have a very high risk of multiple pregnancy when FSH is used. Conversion to an IVF cycle is often used to control multiple pregnancy risk by only replacing one or two embryos. IVF pregnancy rates can be up to 40-50% per cycle depending on age. If too much FSH is given the patient may develop over-stimulation syndrome. This is characterised by sore ovaries and a very swollen abdomen. It occurs about 7 to 10 days after ovulation and mostly in patients who are pregnant. It is actually very rare in patients who are having ovulation induction with FSH and then intercourse. Usually these patients do not have enough eggs growing to make overstimulation syndrome common. It is however much more common in patients who grow large numbers of eggs with FSH, usually on the IVF program. The advantages of FSH treatment therefore include: High pregnancy rates Powerful management of serious ovulation disorders Conversion to versions of the IVF program can occur with high pregnancy rates. The disadvantages of FSH treatment are: It carries a higher community expense although patients receiving this treatment have substantial government subsidies to make it quite affordable. More sophisticated monitoring in the form of blood tests and ultrasound scans are required. Multiple pregnancy rates are higher unless great care is taken. It is a more inconvenient form of therapy as daily injections must be given. New forms of FSH have the advantage of being able to be given by a smaller less painful subcutaneous injection. This is a small injection using a fine needle, which just goes under the surface of the skin into the fat rather than the deeper bigger injection into the muscle. Letrazole and Anastrazole These drugs are ovulation stimulators in a class called “aromatse inhibitors”. They can be used, like Clomid, to grow eggs. However the side effects can be more severe and safety in pregnancy is uncertain. Australian guidelines recommend caution in their use and only as second line therapy after Clomid.