NHS	**Shared Care Guideline for Clomifene (GP Summary)** It is essential that a transfer of care only takes **place** with agreement of the GP and when sufficient information has been received. If the GP does not agree to share care they will inform the Consultant responsible for the patient's care.

Basingstoke, Southampton & Winchester District Prescribing Committee	**Specialist Contact Details** **Name:**_____ **Location:**_____ **Date:**_____ **Tel:**_____	**Patient ID Label** **Surname:**_____ **Forename:**_____ **NHS Number:**_____ **Date of Birth:**_____

Indications	To induce regular unifollicular ovulation, to achieve a singleton pregnancy. For women with anovulatory subfertility, caused by polycystic ovarian syndrome or hypothalamic amenorrhoea (hypogonadotrophic hypogonadism).
Specialist responsibilities	• Specialist to prescribe initial treatment until ovulation is achieved – the initial length of treatment will vary between one and three cycles. • Treatment will be determined by the following criteria: 1. In oligo-/amenorrhoea exclude pregnancy and give medroxyprogesterone acetate 5mg orally twice a day for 5 days to induce a withdrawal bleed 2. Start treatment on day 2-6 of cycle (natural or induced) 3. Start at **50mg once a day for 5 days only** 4. Carry out follicular tracking by ultrasound scan from day 10-14 5. Luteal phase serum progesterone to confirm ovulation 6. If no menstruation by day 35 carry out a pregnancy test - if not pregnant, withdrawal bleed should be induced **7. If unresponsive to first cycle by scan and progesterone blood test, increase dose in second cycle to 100mg once a day for five days.** 8. When ovulation has been confirmed, continue on same dose for maximum duration of 6 cycles per episode of treatment. 9. If patient ovulates but does not become pregnant, refer for assisted conception if further treatment is agreed. 10. 70% of women will ovulate on clomifene citrate • Specialist to counsel patient to be aware of symptoms of ovarian hyperstimulation i.e. pericardial effusion, anasarca, hydrothorax, renal failure, pulmonary oedema, ovarian haemorrhage, deep venous thrombosis, torsion of the ovary and acute respiratory distress. • Advise patient to notify specialist of any symptoms of abdominal or pelvic pain, weight gain, discomfort or distension or visual disturbances after taking clomifene tablet.
GP responsibilities	• Continue prescribing for the remainder of the course of treatment as requested by the specialist. This will generally be: ➢ Up to 5 cycles for patients on 50mg once a day for 5 days per cycle (maximum of 25 x 50mg tablets). ➢ Up to 4 cycles for patients on 100mg once a day for 5 days per cycle (maximum of 40 x 50mg tablets).

	Where a dose of greater than 100mg daily is required, or the course of treatment is extended beyond a total of 6 months, prescribing should remain within the specialist service. • Monitor treatment and take relevant action as specified below.
Primary care monitoring	Be aware of symptoms of ovarian hyperstimulation i.e. pericardial effusion, anasarca, hydrothorax, renal failure, pulmonary oedema, ovarian haemorrhage, deep venous thrombosis, torsion of the ovary and acute respiratory distress. Advise patient to notify GP of any symptoms of abdominal or pelvic pain, weight gain, discomfort or distension or visual disturbances after taking clomifene tablet
Actions to be taken in response to monitoring	It is extremely unlikely that a patient will develop ovarian hyperstimulation with clomifene but in the event of it occurring, admit patient to hospital for review by gynaecology team. If visual disturbances occur, treatment should be stopped immediately and patient referred back to fertility clinic for further management plan. Symptoms usually resolve spontaneously on discontinuing treatment. If symptoms persist, GP to manage as felt appropriate. Hyperlipidaemia is unlikely for the doses and duration used but if it occurs, it should be managed as felt appropriate by GP. For all other minor side effects, if there are concerns, refer back to the Fertility Team at UHS.
Contra-indications	• Pregnancy • Liver disease or history of liver dysfunction • Abnormal uterine bleeding of undetermined cause • Hormone dependent tumours • Ovarian cysts (other than in association with polycystic ovary syndrome)
Cautions	• Pre-existing or family history of hyperlipidaemia • Ectopic pregnancy possible • Incidence of multiple births increased • Ovarian hyperstimulation syndrome • Polycystic ovary syndrome (cysts may enlarge during treatment, also exaggerated response to usual doses) • Uterine fibroids (risk of further enlargement of fibroids) • Driving – in event of visual disturbances
Important adverse effects & management	• Abdominal distension/discomfort • Visual disturbances e.g. blurring, spots or flashes (stop immediately) • Weight gain • Dizziness, light-headedness • Ovarian enlargement • Ovarian cysts • Vasomotor flushes • Nausea & vomiting • Breast tenderness • Headache • Intermenstrual spotting or menorrhagia • Endometriosis or exacerbation of pre-existing endometriosis • Ovarian hyperstimulation – (withdraw treatment) • Convulsions • Hair loss

	• Weight gain • Rashes • Anxiety/Depression/Mood disturbances • Fatigue • Insomnia • Tachycardia/Palpitations
Important drug Interactions	None known

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