**Practice Trends** OB.GYN. NEWS • July 1, 2006

## Community Health Centers Starving for Staffing

BY KATE JOHNSON

Montreal Bureau

ommunity health centers are currently clinically understaffed and will likely face increasing shortages that may limit their expansion, according to a study by the rural health research centers of both the University of Washington, Seattle, and the University of South Carolina, Columbia, and by the National Association of Community

Health Centers (JAMA 2006;295:1042-9).

"Workforce shortages may impede the expansion of the U.S. [community health center] safety net, particularly in rural areas," reported Dr. Roger A. Rosenblatt from the University of Washington, and his colleagues.

The study surveyed 846 federally funded community health centers (CHCs) within the 50 states and the District of Columbia. Mailed questionnaires and telephone surveys asked CHC chief executive officers about staffing and recruiting patterns, use of federal and state recruitment programs, and perceived barriers to re-

Responses were obtained from 79% of the population and revealed that funded clinical staff vacancies are common. The average CHC has 13% of its family physician full-time equivalent positions unfilled. Rural CHCs reported a significantly higher proportion of these vacancies, as well as recruiting difficulties, compared with their urban counterparts, with more than one-third of rural CHCs reporting that they had been trying to recruit a family physician for more than 7 months. "It would require more than 400 FTE family physicians to fill all the vacancies for this discipline," noted the authors.

Some of the greatest recruitment difficulties were reported for obstetrician/gynecologists and psychiatrists; rural locations reported more than 20% of funded positions vacant, and they had more recruitment difficulties, compared with urban CHCs. Dentists' vacancies also were indicated, with more than half of rural CHCs reporting a vacant position for 7 months or longer. Less difficulty was reported in recruiting nurse-practitioners and physician assistants, with no significant rural-urban differences.

When asked to indicate perceived barriers to recruitment and retention of both rural and urban CHC physicians and nurses, respondents consistently noted the inability to offer competitive compensation packages.

"The lack of spousal employment opportunities, lack of cultural activities and opportunities, lack of adequate housing, and poor-quality schools were perceived as disproportionately greater barriers for rural centers," noted the authors. Survey respondents suggested three potential interventions to address these perceived barriers: better capacity to provide annual salary increases, more National Health Service Corps loan repayment incentives, and greater visibility of CHCs as desirable practice opportunities during training.

'The clinical role of CHCs is dependent on primary care clinicians, both physicians and nonphysician clinicians," the authors wrote, noting that the declining production of family physicians from residency programs "may lead to serious workforce shortages, particularly in rural CHCs." Roughly 66% of the responding CHCs indicated their plans to expand as part of a federal 5-year initiative to increase spending on CHCs by at least \$2.2 billion through fiscal year 2006.

However, the decline in "physicians choosing generalist careers may be the rate-limiting step in the nation's ability to staff CHCs and may lead to renewed shortages of safety-net and rural physicians generally," they wrote.

The authors made several suggestions, including the following, for federal and state governments, as well as for CHCs:

- ▶ Bolstering elements of the Health Professions Educational Assistance Act of 1976, the only federal program aimed at encouraging primary care clinicians who are likely to practice in underserved areas.
- ▶ Increasing the use of nurse-practitioners and physician assistants.
- ► Creating new alliances between CHCs and primary care training programs.
- ► Expanding the National Health Service Corps and related programs that provide financial incentives to attract health care clinicians to underserved areas.
- ▶ Developing new approaches to loan repayment plans.
- ► Creating additional incentives for rural



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ESTROGENS INCREASE THE RISK OF ENDOMETRIAL CANCER

Close clinical surveillance of all women taking estrogers is important. Adequate diagnostic measures, including endometrial sampling when indicated, should be undertaken to rule out malignancy in all cases of undiagnosed persistent or recurring abnormal vaginal bleading. There is no evidence that the use of "retural" estrogers results in a different endometrial risk profile than synthetic estrogers of equivalent estrogers does. (See WarRININGS, Malignant endometrial cancer.)

CARDIOVASCULAR AND OTHER RISKS

Estrogers with or without progestins should not be used for the prevention of cardiovascular disease or demetria. (See WARRININGS, Cardiovascular disorders and Dementia.)

The Women's Health Initiative (WHI) study reported increased risks of stroke and deep vein thrombosis in construency unonen (50 to 79 years of age) during 6.8 years of treatment with conjugated estrogers (0.625 mg) relative to placebo. (See CLINICAL PHARMACOLOGY, Clinical Studies in full Prescribing Information and WARNINGS, Cardiovascular disorders.)

WARNINGS, Cardiovascular disorders.)
The WHI study reported increased risks of myocardial infarction, stroke, invasive breast cancer, pulmorary emboli, and deep vein thrombosis in postmenopausal women (50 to 79 years of apa) during 5 years of treatment with oral conjugated estrogers (0.625 mg) combined with medroxyprogesterone acatele (2.5 mg) relative to placebo. (See CLINICAL PHARMACOLOGY, Clinical Studies in bill Prescribing Information and WARNINGS, Cardiovascular disorders and Malignant neoplasms. Breast cancer.)
The Women's Health Initiative Memory Study (WHINIS), a substudy of WHI, reported increased risk of developing protable dementia in postmenopasal women for day par order during 3 years of treatment with on calculaged estopages acroine and during 4 years of treatment with on pulmost part of the protection of the prot

Other doses of conjugated estrogens and medroxyprogesterone acetate, and other combinations and dosage forms of estrogens and progestins were not studied in the WHI clinical trials and, in the absence of comparable data, these risks should be assumed to be similar. Because of these risks, estrogens with or without progestins should be ffective doses and for the shortest duration consistent with treatment goals and risks for the individual woma

### INDICATIONS AND USAGE

Premarin (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae.

# CONTRAINDICATIONS \*\*Pemarin Vaginal Cream should not be used in women with any of the following conditions: 1. Undiagnosed abnormal genital bleeding. 2. Known, suspected, or history of cancer of the breast. 3. Known or suspected estrogen-dependent encoplasia. 5. Active deep well mortonosis, pulmornary embolism or a history of these conditions. 6. Active deep well mortonosis, pulmornary embolism or a history of these conditions. 6. Active for recent (e.g., within past year) arterial thromboembolic disease (e.g., stroke, myocardial infarction). 6. Liver dysfunction or disease. 7. Pemarinary laginal Cream should not be used in patients with known hypersensitivity to its ingredients. 8. Known or suspected pregnancy. There is no indication for Premarin Vaginal Cream in pregnancy. There appears to be little or no increased risk of birth delects in children born to women who have used estrogen and progestins from oral contraceptives inadvertently during pregnancy. (See PRECAUTIONS.) WARNINGS

discontinued immediately.

Risk factors for arterial vascular disease (e.g., hypertension, diabetes mellitus, lobacco use, hypercholesterolemia, and obesity) and/or venous thromboembolism (e.g., personal history or family history of VTE, obesity, and systemic lugus erythematisms) should be managed appropriately.

a. Cornary heart disease and stroke. In the estrogen alone substudy of the Women's Health Initiative (WHI) study, an increased risk of stroke was observed in women receiving placetor (e.d. vs. 25 per 1000 women-years). The increase in risk was observed in year one and persisted. (See CLINICAL PHARMACOLOGY, Clinical Studies in full Prescribing Information.)

(See CLINICAL PHARMACOLOGY, Clinical Studies in full Prescribing Information.)
In the estrogen plus progestin substudy of WHL an increased risk of coronary heart disease (CHD) events (defined as nonfatal impocardial infarction and CHD death) was observed in women receiving PREMPHO (0.625 mg conjugated estrogens plus 2.6 mg medicoryoprogesterone actable) per day compared to nomen receiving placebo (37 vs 30 per 10000 women4-years). The increase in risk was observed in year one and persisted.
In the same estrogen plus progestin substudy of the WHL an increased risk of stroke was observed in women receiving PREMPHO compared to women receiving placebo (29 vs 21 per 10000 women4-years). The increase in risk was observed after the first year and persisted.
In postmenopausal women with documented heart disease (n = 2.763, average age 66.7 years) a controlled clinical trial of secondary prevention of cardiovascular disease (retard and Estrogentyrogestin Replacement Study, reft.PS) treatment with PREMPHO (0.625 mg conjugated estrogen but 2.5 mg medicoryopscisterors earticle per object of the production of the confidence of the production of the production of the confidence of the production of the placebo group in press 1 but not discussed the production of the placebo group in PERS II undown or production of the placebo group in the placebo group in press 1 but not discussed the placebo group in the PERS II undown or the PERMPHO comparable to those used to treat cancer of the numbrate hand heave the one observation in a force.

the placebo group in HERS, HERS II, and overall. Large doses of estrogen (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown in a large prospective clinical trial in men to increase the risks of nontialal mycardial infaction, pulmonary embolism, and thromotophilabilis.

b. Venous thromboembolism (VTE). In the estrogen alone substudy of the Women's Health Initiative (WHI) study, an increased risk of deep vein thrombosis was observed in normer receiving Premario compared to placebox (21 vs. 15 per 10,000 women-years). The increase in VTE risk was observed during the first year. (See CLINICAL PHARMACOLOGY, Clinical Studies in full Prescribing Information.)

CLIMONE PREMINDED COLD, coming a source in our resoluting international in the estageng long progestin substituty of WH, a 2-fold greater alse of VTE, including deep venous thrombosis and pulmonary embolism, was observed in women receiving PREMPRO compared to women receiving placebo. The rate of VTE was 34 per 10,000 women-years in the Prempro group compared to 16 per 10,000 women-years in the placebo group. The increase in VTE risk was observed during the first year and persisted.

If leasible, estrogers should be discontinued at least 4 to 6 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of nonnoned immobilization.

of proingest immountation.

2. Malignant peoplasms.

a. Endometrial cancer. The use of unopposed estrogens in women with intact uteri has been associated with an increased risk of endometrial cancer. The reported endometrial cancer risk among unopposed estrogen users is about 2 to 12-fold greater than in non-users, and appears dependent on duration of treatment and on estrogen dose. Most studies shown no significant increased risk associated with use of estrogens for less then one year. The greatest risk appears associated with prolonged use, with increased risks of 15- to 24-fold for five to ten years or more and this risk has been shown to persist for at least 8 to 15 years after estrogen therap

prolonged use, with increased risks of 15- to 24-bild for the to be in-years or more and this risk has been shown to persist to at least 8 to 15 years after estrogen threapy is discontinued.

Clinical surveillance of all women taking estrogen/progestin combinations is important. Adequate diagnostic measures, including endometrial sampling when indicated, should be undertaken to use out malignancy in all cases of undagnosed persistent or recurring abnormal vaginal bleeding. There is no evidence that the use of natural estrogens results in a different endometrial risk profile than synthetic estrogens of equivalent estrogen dose. Adding a progestin to postmenopasal estrogen therapy has been shown to reduce the risk of endometrial hyperplasia, which may be a piecursor to endometrial cancer.

b. \*\*Presal\*\* cancer\*\*. In some studies, the use of estrogens and progestins by postmenopasal women has been reported to increase the risk of breast cancer. The most important randomized clinical trip providing information about this sizes is the Wilmer's Health intiative (WHI) this of estrogen plus progestin (see CLINICAL PHARRIMACOLOGY, Clinical Studies in full Prescribing Information.) The results from observational studies are generally consistent with those of the WHI clinical trial.

After a mean follow-up of 5.5 years, the WHI trial reported an increased risk of breast cancer in women who took estrogen plus progestin. Observational studies have also reported an increased risk in the religionship of the plus progestin. Observational studies have also reported an increased risk in the religionship to the plus progestin combination therapy, and as male increased risk for estrogen plus progestin combination therapy as compared to estrogen alone therapy. However, these studies have not found significant variation in the risk of breast cancer among different estrogens plus progestin combination therapy as compared to estrogen alone therapy, the vexell relative risk of invasive breast cancer was 16, and the absolute risk was 40

breast earninations by a healthcare provider and perform monthly breast self-examinations. In addition, marimography examinations should be scheduled based on patient age, rick factors, and prior marringora results.

3. Dementia. In the estrogen alone Women's Health Initiative Memory Study (WHIMS), a substudy of WHI, a population of 2,947 hysterectomized women aged 65 to 79 years was randomized to Perenarin (10x25 mg) or placebo. In the estrogen plus progestin WHIMS substudy, a population of 4,532 postmenopausal women aged 65 to 79 years was randomized to PERMPO (10x55 mg). En plus or placebo.

In the estrogen alone substudy, after an average follow-up of 5.2 years, 28 women in the estrogen alone group and 19 women in the placebo group were diagnosed with protable dementia. The relative rick of protable dementia for Perenarin alone versus placebo was 45 versus 26 zesse per 1000 women-years.

In the estrogen plus progestin substudy, after an average follow-up of 4 years, 40 women in the estrogen plus progestin group and 21 women in the placebo group were diagnosed with protable dementia. The relative rick of protable dementia for PEMMPO reversus placebo was 5 versus 26 zesse per 10,000 women-years.

Since both substudies were conducted in women aged 65 to 79 years, it is unknown whether these findings apply to younger postmenopausal women. (See BOXED

### WARNINGS and PRECAUTIONS, Geriatric Use.)

4. Gallbladder disease. A 2- to 4-fold increase in the risk of gallbladder disease requiring surgery in postmenopausal women receiving postmenopausal

Voluments as been reported.

Hypercalcemia. Estrogen administration may lead to severe hypercalcemia in patients with breast cancer and bone metastases. If hypercalcemia occurs, use of the up should be stoped and appropriate measures taken to reduce the serum calcium level.

Visual abnormalities. Retinal vascular thrombosis has been reported in patients receiving estrogens. Discontinue medication pending examination if there is sudden partial compilete loss of vision, or a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, estrogens should be discontinued.

Addition of a progestin when a woman has not had a hysterectomy. Studies of the addition of a progestin for 10 or more days of a cycle of estrogen atministration or daily with estrogen in a continuous regimen have reported a lowered incidence of endometrial hyperplasia than would be induced by estrogen freatment

1. Administration of day with estogen in a continuous regimen have reported a lowered incidence of endometrial hyperplasia than would be induced by estrogen treat alone. Endometrial hyperplasia may be a precursor to endometrial cancer. There are, however, possible risks that may be associated with the use of progestins with estrogens compared to estrogen-alone regimens. These include a possible increased risk of breast cancer, advises effects on lipoprotein metabolism (e.g., lowering HDL, raising LDL) and impairment of glucose tolerance.

2. Elevated blood pressure. In a small number of case reports, substantial increases in blood pressure been attributed to lidicytocatic reactions to estrog in a large, randomized, placebo-controlled clinical trial, a generalized effect of estrogen therapy on blood pressure was not seen. Blood pressure should be monitored and the processor and the processor in the processor was not seen. Blood pressure should be monitored and the processor and the processor in the processor in the processor was not seen. Blood pressure should be monitored and the processor in the processor in the processor in the processor in the processor is a processor in the processor in the processor in the processor is a processor in the processor in the processor is a processor in the processor in the processor is a processor in the processor is a processor in the processor in the processor is a processor in the processor in the processor in the processor is a processor in the processor in the processor is a processor in the processor in the processor is a processor in the processor in the processor in the processor is a processor in the processor in the

. Hypertriglyceridemia. In patients with pre-existing hypertriglyceridemia, estrogen therapy may be associated with elevations of plasma triglycerides leading to

anorealitis and other complications.

I. Impaired liver function and past history of cholestatic jaundice. Estropens may be poorly metabolized in patients with impaired liver function. For patients with a history of cholestatic jaundice associated with past estropen use or with pregnancy, caution should be evercised and in the case of recurrence, medication should be

discontinued.

\*\*Mypothyroidism\*\*: Estrogen administration leads to increased thyroid-binding globulin (TBG) levels. Patients with normal thyroid function can compensate for the increased TBG by making more thyroid function can compensate for the increased TBG by making more thyroid function can compensate for the replacement therapy who are also receiving estrogens may require increased dises of their thyroid eplacement therapy. These patients should have their thyroid function monitored in order to maintain their free thyroid formone levels in an acceptable range.

6. Fluid retention. Because estrogens may cause some degree of fluid retention, patients with conditions that might be influenced by this factor, such as cardiac or renal dysfunction, warrant careful observation when estrogens are prescribed.

7. Hyporateemia. Estrogens should be used with caution in individuals with severe hypocalcemia.

8. Mearine accept. The actingen plants promosting substruct MMM ancorted that after an average follow-up of 5.6 wascr, the rabidium risk for overage career for actingents.

7. Hypocalcemia. Estrogens should be used with caution in individuals with severe hypocalcemia.
8. Ovarian cancer. The estrogen plus progestin substudy of WHI reported that after an average follow-up of 5.6 years, the relative risk for ordinar cancer for estrogen plus progestin versus placebo was 1.58 (95% confidence interval 0.77-3.29 but was not statistically significant. The absolute risk for estrogen plus progestin versus placebo was 1.58 (95% confidence interval 0.77-3.29 but was not statistically significant. The absolute risk for estrogen plus progestin versus placebo was 4.2 versus 2.7 cases per 10,000 women-years. In some epidemiologic studies, the use of estrogen-only products, in particular for ten or more years, has been associated with an increased risk of overlar cancer. Other epidemiologic studies, the use not found these essociations.
9. Exacerbation of endometriosis. Endometriosis may be exacerbated with administration of estrogen therapy.
A law cases of malignant transformation of residual endometrial implants have been reported in women treated post-hysterectomy with estrogen alone therapy. For patients known to have residuel endometriosis places by-hyderectomy, the addition of progestin should be considered in women treated post-hysterectomy with estrogen alone therapy. For patients known to have residuel endometriosis places they are reported in women treated post-hysterectomy with estrogen alone therapy. For patients known to have residuel endometriosis places they are reported in women treated post-hysterectomy with estrogen alone therapy. For patients known to have residuel endometriosis post-hysterectomy, the addition of progestin is shown to have residence and the patient patients. Such as a such

exponentials, and inequal, relanguistical and should be used with calculuin informer with these conditions. The potential for Premarin Vaginal Cream exposure has been reported to weaken later conditions. The potential for Premarin Vaginal Cream to weaken and contribute to the failure of conditions, displanguins, or cervicial cagis made of faller or notibe should be considered.

B. Patient Information Physicians are advised to discuss the contents of the PATIENT INFORMATION leaflet with patients for whom they prescribe Premarin Vaginal Cream.

C. Laboratory Tests Estrogen administration should be guided by clinical response at the lowest dose for the treatment of postmenopausa

D. Orugi Aboratory Test Interactions
1. Accelerated protomorbin time, partial thromboplastin time, and platelet aggregation time; increased platelet count, increased factors II, VIII artigen, VIII artig

4. Increased plasma HDL and HDL<sub>2</sub> cholesterol subfraction concentrations, reduced LDL cholesterol concentration, increased triplyceride levels.

E. Carcinogenesis, Mutagenesis, Impairment of Fertility (See BOXED WARNINGS, WARNINGS, and PRECAUTIONS.)

F. Pregnancy Premarin Vaginal Cream should not be used during pregnancy. (See CONTRAINDICATIONS.)

G. Nursing Mothers Estrogen administration to nursing mothers has been shown to decrease the quantity and quality of breast milk. Detectable amounts of estrogens have been identified in the milk of mothers receiving the drug. Caution should be exercised when Premarin Vaginal Cream is administered to a nursing woman.
H. Pediatric Use Estrogen therapy has been used for the induction of puberty in adolescerts with some forms of pubertal delay. Safety and effectiveness in pediatric patients have not oftenwise been established.

params make not use was eare reasonation.

Lange and repeated dosses of estrogen over an extended time period have been shown to accelerate epiphyseal closure, which could result in short adult stature if treatment is initiated before the completion of hybriologic puberty in normally developing children. If estrogen is administered to patients whose borne growth is not complete, periodic monitoring of borne maturation and effects on epiphyseal contents is recommended during estrogen administration.

Estrogen treatment of prepubertal girls also induces premature breast development and vaginal comilication, and may induce vaginal bleeding. In boys, estrogen treatment may modify the normal pubertal process and induce yencomestia. See INDICATIONS, see DOSAGE AND ADMINISTRATION section in full Prescribing Information. Generative Uses of the belal number of subjects in the section gain class subjects by the Women's Health Initiative (WHI) study. 45% in = 4,94% proceed 5 years and over, while 7,1% (n = 767) were 75 years and over. There was a higher relative risk (Premarin vs. placebo) of stroke in women less than 75 years of age compared to

women 75 years and over.

In the estrogen alone substauly of the Women's Health Initiative Memory Study (WHIMS), a substudy of WHI, a population of 2,947 hysterectomized women, aged 65 to 79 years, was randomized to Premarin (0.625 mg) or placate). In the estrogen alone group, after an average follow-up of 5.2 years, the relative risk (Premarin vs. placateo) of probable demental was 1.49 (95% C1 0.83 -2.65).

Of the total number of subjects in the estrogen pis progestin substudy of the Women's Health initiative study, 44% (n=7,200) were 65 years and over, while 6.6% (n = 1,085) were 75 years and over. While 6.6% (n = 1,085) were 75 years and over. While 6.6% (n = 1,085) were 75 years and over. While 6.6% (n = 1,085) were 75 years and over. While 6.6% (n = 1,085) were 75 years and over. While 6.6% (n = 1,085) were 75 years and years (have compared to women less than 75 years of age. In the estrogen plus progestin substudy of WHIMS, a population of 4,532 postmenopausal women, aged 65 to 79 years, was randomized to PREMPRO (0.625 mg/2.5 mg) or placebol. In the estrogen plus progestin group, after an average follow-up of 4 years, the relative risk (PREMPRO vs. placebol) of probable dementia was 2.05 (95% CT 121-3.48).

CH 121-349.

Proling the events in women receiving Premarin or PREMPRO in comparison to those in women on placebo, the overall relative risk for probable dementia was 1.76 (95% CH 1.19-2.60). Since both substituties were conducted in women aged 65 to 79 years, it is unknown whether these findings apply to younger postmenopausal women. (See **BOXED WARNINGS** and **WARNINGS**, **Dementia**.)

are have not been sufficient numbers of geriatric patients involved in studies utilizing Premarin Vaginal Cream to determine whether those over 65 years of age differ in younger subjects in their response to Premarin Vaginal Cream. See BOXED WARNINGS. WARNINGS. and PRECAUTIONS.

Systemic absorption may occur with the use of Premarin Vaginal Cream. Warnings, precautions, and adverse reactions associated with oral Premarin treatment should be aken into account. The following additional adverse reactions have been reported with estrogen and/or progestin therapy:

The following additional adverse reactions have been reported with estrogen and/or progestin therapy:

Genitourinary system: Breakthrough bleeding, spotling, changes in vaginal bleeding pattern and abnormal withdrawal bleeding or flow; dysmenorthea; increase in size of uternie biomyromata, vaginitis, including varginal candidiasis; change in cervical erosion and in dignee of cervical secretion; cystilis-like syndrome, application site reactions of vulvoraginal discontion including burning and irritation; genital pruritus, ovarian cancer, endometrial hyperplasis; endometrial cancer, prescolous puberly.

2. Prassis: Finderiness, pain, enlargement, secretion; treast cancer, throogst-breast changes.

3. Cardiovascular: Deep and superficial venous thrombosis, pulmonary embolism, thrombophiebitis, myocardial infaction, stroke; increase in blood pressure.

4. Gastrovinestrant: Naves, vomiting, abdominal cramps, bloating; cholestatic jaundice; parcreatits; increased incidence of galibladder disease; enlargement of hepatic hermangiomas.

5. Skin: Chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; nombre; erythema nodosum; hemorrhagic eruptio

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The continuation interaction interaction in the content lenses.

Eyes: Retinal vascular thrombosis; intolerance to contact lenses.

Eyes: Retinal vascular thrombosis; intolerance to contact lenses.

Central Mervous System: Headache, migraine, diziness, renousness; mood disturbances; irribability, mental depression; chorea; evacerbation of epilepsy; demental Moscollaneous; Interace or decrease in weight, reduced acordividuals tolerance; glouces intolerance; aggravation of porphytic; edems; changes in libido; urticaria, angioedema, araphylactoid/anaphylactic reactions; hypocalcemia, evacerbation of asthma; increased triglycerides; arthralgias; leg cramps.

Serious III effects have not been reported following acute ingestion of large doses of estrogen/progestin containing drug products by young children. Overdosage of strogens may cause nausea and vomiting, and withdrawal bleeding may occur in females. This brief summary is based on PREMARIN® (conjugated estrogens) Vaginal Cream Prescribing Information W10413C008 ET01, revised September 12, 2005.

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