Management of Pelvic Inflammatory Disease (PID)

NHS Tayside

- Presence of inflammation and infection in the upper genital tract and usually results from ascending infection from the vagina causing a spectrum of disease including endometritis, salpingitis, parametritis, oophoritis, tubo-ovarian abscess and/or pelvic peritonitis.
- Untreated PID is associated with high morbidity, with increased subsequent diagnoses of endometritis, abdominal pain, tubal factor infertility and ectopic pregnancy than controls and increased risk of hysterectomy.
- May be symptomatic or asymptomatic. Even when present signs and symptoms lack sensitivitity and specificity.
- Causative organisms include *N. gonorrhoeae*, *Chlamydia trachomatis*, *Garderella vaginalis*, anaerobes, coliforms and these are covered with empirical antibiotic treatment recommended below.
- Higher risk if young age (usually <25) or new sexual partner
- *Taking a sexual history should include whether sexually active, recent change of partner, past history of STI and presence of abnormal vaginal discharge or bleeding.

Assessment: **History** (which should include sexual* and contraceptive histories) **Bimanual examination**

The following symptoms and signs are commonly (but not always) present:

- lower abdominal pain (usually bilateral)
- lower abdominal tenderness (usually bilateral)
- abnormal vaginal or cervical discharge often purulent
- temperature >38°C in moderate to severe disease
- abnormal vaginal bleeding including post coital or intermenstrual bleeding
- adnexal tenderness/mass and/or cervical motion tenderness on bimanual examination
- deep dyspareunia

Differential diagnosis:

- Ectopic pregnancy
- Endometriosis – establish relationship between symptoms and menstrual cycle
- Functional pain – may be associated with long standing symptoms
- UTI – often associated with dysuria and/or frequency – refer to Antibiotic Man or Antibiotic Woman
- IBS – disturbance in bowel habit and persistence of symptoms over a prolonged period are common
- Acute appendicitis – N&V occur in most patients
- Ovarian cyst complications – often very sudden onset
- Post natal endometritis– refer to Antibiotic Woman

REFERRAL FOR INPATIENT TREATMENT: Contact oncall Gynae team

- surgical emergency cannot be excluded
- clinically severe disease or sepsis – calculate NEWS score
- clinical signs of tubo-ovarian abscess
- lack or response or intolerance to oral therapy after 72 hours
- pregnancy

NO

YES

OUTPATIENT INVESTIGATIONS:

- Full sexual health screen including HIV & Syphilis serology
- MSSU for culture and sensitivity (red top boricon container)
- Urine pregnancy test • Urinalysis • FBC, CRP
- Self(or clinician) taken vulvovaginal swab for chlamydia and gonorrhoea PCR is essential
- Near patient microscopy of HVS and endocervical swabs if available

INPATIENT INVESTIGATIONS:

- As per outpatient +
- if patient has sepsis – lactate and blood cultures (prior to antibiotic therapy)
- Transvaginal scan if tubo-ovarian abscess suspected

OUTPATIENT TREATMENT: For 14 days

Ofloxacin 400mg twice daily + Metronidazole 400mg twice daily

OR *patients < 18 or if patient at high risk of GC* (partner with gonorrhoea, sexual contact abroad, or gram negative diplococci on microscopy of endocervical swab):
IM Ceftriaxone 1g single dose
+
Doxycycline 100mg twice daily + Metronidazole 400mg twice daily

If treated in primary care and no improvement refer to guidance booklet (currently being updated)

Patients with an IUCD do not need to have this routinely removed. Treatment should be provided as normal with follow up to review clinically. Where an IUCD is removed, patients should be offered hormonal emergency contraception where relevant.

General Advice for Patient:

- Rest
- Analgesia
- Sexual abstinence until they and partner/s have completed treatment and follow up
- Provide written information leaflet

INPATIENT TREATMENT:

IV Ceftriaxone 2g daily + IV Metronidazole 500mg three times daily + PO Doxycycline 100mg twice daily
(or IV Azithromycin 500mg daily if not able to take oral)
Review IV antibiotics daily and follow IV to oral switch criteria
Step down to oral doxycycline 100mg twice daily + metronidazole 400mg twice daily to complete 14 days

Severe penicillin allergy:
IV Clindamycin 900mg tds + IV Gentamicin as per local guidance
Step down to oral doxycycline and metronidazole as above

Pregnancy:
IV Ceftriaxone 2g daily + IV Erythromycin 500mg four times daily + IV Metronidazole 500mg three times daily
Step down to oral erythromycin 500mg qds + oral metronidazole 400mg tds to complete 14 days

Pregnancy and Severe penicillin allergy: IV Clindamycin 900mg tds + IV Gentamicin as per local pregnancy guidance. Step down to oral clindamycin 450mg three times daily to complete 14 days

Patients with an IUCD as per advice in outpatient box.

References:
BASHH 2011 IUSTI 2017 CDC 2015

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Follow Up:

- Partner Notification: current partner should be offered sexual health screening and treatment as contact. Patients should be advised to discuss with their partner who can present to sexual health or general practice.
- Review outpatients at 72 hours: failure to improve suggests need for further investigation or inpatient treatment
- Review at 2-4/52 to assess compliance, clinical response to treatment and arrange any other follow up