

Management of Pelvic Inflammatory Disease (PID)

- 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, hysterectomy, abdominal pain, tubal factor infertility and ectopic pregnancy than controls
- May be symptomatic or asymptomatic. Even when present signs and symptoms lack sensitivity and specificity.
- Causative organisms include *N. gonorrhoeae*, *Chlamydia trachomatis*, *Gardnerella 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)

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
- temperature >38°C
- abnormal vaginal bleeding
- adnexal tenderness/mass and/or cervical motion tenderness on bimanual examination

Bimanual examination

- deep dyspareunia

Investigations:

- Full sexual health screen including HIV serology and Syphilis serology
- Urine pregnancy test
- Urinalysis
- U&Es, FBC, CRP
- HVS and endocervical swabs for culture and sensitivity - enter '?PID' on request
- Near patient microscopy of HVS and endocervical swabs if available
- In addition if patient has sepsis – lactate and blood cultures (prior to antibiotic therapy)
- MSSU for culture and sensitivity (red top boricon container)
- Endocervical swab for combined chlamydia and gonococcal PCR
- Transvaginal scan if tubo-ovarian abscess suspected

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 frequency – refer to [Antibiotic Man or Antibiotic Woman](#)
- Acute appendicitis – N&V occur in most patients
- Ovarian cyst complications – often very sudden onset
- Postnatal endometritis – refer to [Antibiotic Woman](#)

NO

YES

Refer for Inpatient Treatment: Discuss with oncall Gynae team

- surgical emergency cannot be excluded
- clinically severe disease or sepsis
- signs of tubo-ovarian abscess
- lack of response or intolerance to oral therapy
- pregnancy

OUTPATIENT TREATMENT: For 14 days

Ofloxacin 400mg twice daily + Metronidazole 400mg twice daily

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 500mg single dose
(1g vial reconstituted with 3.5ml of lignocaine 1% solution.
2.1ml of resulting solution contains 500mg)

+
Doxycycline 100mg twice daily
+
Metronidazole 400mg twice daily

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 doxycycline)
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 + oral metronidazole to complete 14 days

Pregnancy and Severe penicillin allergy: seek advice

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 contraception where relevant.

References:

[BASHH 2011](#) [IUSTI 2012](#) [CDC 2010](#)

Developed by: Sexual Health/O&G/
Microbiology/Pharmacy
Approved by: AMG Mar 2015
Review: Mar 2017

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