Melbourne Sexual Health Centre
TREATMENT GUIDELINES

Melbourne Sexual Health Centre
A part of Alfred Health

PELVIC INFLAMMATORY DISEASE

March 2011

Pelvic Inflammatory Disease (PID) is infection and inflammation of the upper genital tract in women, typically involving the fallopian tubes, ovaries and surrounding structures. The exact incidence is unknown because of the difficulty in clinical diagnosis. Laparoscopy is the best single diagnostic test but it is invasive and not used routinely in clinical practice especially in mild to moderate PID when it also has a low sensitivity. Following PID, 20% of women become infertile, 20% develop chronic pelvic pain and 10% of those who conceive have an ectopic pregnancy. Repeated episodes of PID are associated with a four to six times increase in risk of permanent tubal damage. Delay in treatment over 48 hours increases the risk of ectopic pregnancy and infertility threefold.

PID often has a polymicrobial aetiology so treatment must be broad spectrum but must also be targeted to cover the commoner identifiable known bacterial causes. Treatment will depend on local prevalence data but may therefore need to cover Chlamydia trachomatis, Neisseria gonorrhoea and Mycoplasma genitalium (MG) as well as some of the anaerobic organisms that are endogenous to the lower genital tract and are often associated with bacterial vaginosis (BV).

As PID is often caused by sexually transmissible pathogens in addition to organisms endogenous to the lower genital tract, risk factors associated with PID are the same as those for sexually transmissible infections; young age, reduced socioeconomic circumstances and recent new sexual partner.

DIAGNOSIS

PID should be considered in a woman at risk of STIs if she has lower abdominal or pelvic pain with no other cause for her pain and on examination she has at least one of the following present:
cervical motion tenderness OR uterine tenderness OR adnexal tenderness.
The presence of WBCs on endocervical and/or vaginal smears is non specific for a diagnosis of PID (poor PPV 17%) but their absence has a good NPV of 95% and may be helpful in excluding PID.

DIFFERENTIAL DIAGNOSIS

- Ectopic pregnancy.
- Appendicitis.
- Endometriosis.
- Ovarian cyst complication.

MANAGEMENT OUTPATIENT TREATMENT - MILD TO MODERATE PID

- High degree of suspicion - PID is under-diagnosed.
- Treat early - treatment should not be delayed waiting for swab results as swabs are commonly negative despite a clinical diagnosis of PID.
- Delayed treatment increases the chance of complications.
- Exclude pregnancy.
- Consider pelvic ultrasound to exclude mass lesions.

TREATMENT

Azithromycin 1gm single dose PLUS Doxycycline 100mg bd for 2 weeks PLUS Metronidazole 400mg bd for 2 weeks.
If there is a history of recent sex with a partner from overseas or any other reason to suspect gonorrhoea, add:

- Ceftriaxone 500mg IMI.

If the woman is a contact of Mycoplasma genitalium, omit doxycycline and metronidazole and use moxifloxacin 400mg daily for 14 days.
Partners should be notified and treated.

Disclaimer
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PID with an IUCD in situ

Consider removing the IUCD in women with mild to moderate PID if there is no clinical improvement at 72 hours. There is limited randomised controlled trial evidence as to whether an IUCD should be removed or left in place with a diagnosis of mild to moderate PID although there is a suggestion that short term clinical outcomes may be better if it is removed. Ideally at least 36 hours of antibiotics should be given prior to removal of the IUCD. However hormonal emergency contraception may need to be offered in this situation if SI has occurred within 7 days of removal of IUCD. If severe PID with an IUCD In situ the patient should be referred to A+E.

REVIEW

Review patient in one week or earlier to assess response to treatment and if clinically responding continue treatment for a full 2 weeks.
If MG test is positive stop doxycycline and metronidazole and start moxifloxacin (400mg a day) for an additional 14 days.

SEVERE PID, OR IF PELVIC MASS IS PRESENT

Refer to emergency department.

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