MSHC
MELBOURNE SEXUAL HEALTH CENTRE

Pelvic inflammatory disease treatment guidelines

Also known as PID

Pelvic inflammatory disease (PID) is inflammation or infection of the reproductive system in the pelvis. PID can be caused by STIs such as chlamydia, gonorrhoea and *Mycoplasma genitalium*.

Causes

PID is the spectrum of inflammatory disorders of the upper female genital tract, including endometritis, salpingitis, tubo-ovarian abscess, and pelvic peritonitis.

PID can lead to infertility, chronic pelvic pain and ectopic pregnancy.

Repeated episodes of PID are associated with an increased risk of permanent tubal damage.

Sexually transmitted pathogens are more likely to be found in younger sexually active women with PID.

PID can be caused by STIs such as chlamydia, gonorrhoea and *Mycoplasma genitalium.*

Treatment for PID should cover *Chlamydia trachomatis* and as well as anaerobic organisms which are often associated with PID.

Treatment for gonorrhoea should be added if suspected and where the prevalence of gonorrhoea is higher.

Mycoplasma genitalium can also cause PID and is less responsive to the recommended treatment for PID.

Refer to:

- Chlamydia treatment guidelines
- Gonorrhoea treatment guidelines
- Mycoplasma genitalium treatment guidelines-

Clinical presentation

While PID may be asymptomatic, symptoms can include:

- pelvic pain
- vaginal discharge
- abnormal vaginal bleeding, including post-coital bleeding
- dyspareunia

Diagnosis

PID diagnosis is often subtle and clinicians need to have a high index of suspicion.

A combination of the presence of symptoms and the following examination findings are used:

- cervical motion tenderness
- uterine tenderness
- adnexal tenderness

The additional presence of signs of lower genital tract inflammation (predominance of leukocytes in vaginal secretions and signs of cervicitis) increases the specificity of the diagnosis.

While laparoscopy is the best single diagnostic test for PID, it is invasive and not used routinely in clinical practice.

Women suspected of having PID should have:

- swabs for microscopy and STI testing (chlamydia, gonorrhoea, and MG)
- bHCG to exclude pregnancy

Consider pelvic ultrasound to exclude other causes of pelvic pain.

Management

Index patient

Condition	Recommended	Comments
Mild to moderate PID	**Doxycycline 100mg PO, twice daily for 14 days** PLUS **Metronidazole 400mg PO, twice daily for 14 days** If gonorrhoea is suspected add **Ceftriaxone 500mg in 2 ml of 1% lignocaine IM, as a single dose.**	Empiric treatment for PID should be initiated early, before swab results. If *M. genitalium* is confirmed, refer to Mycoplasma genitalium treatment guidelines. Women should ideally be reviewed at 72 hours. If there is no clinical improvement, consider an alternative diagnosis and/or referral for further investigation and inpatient treatment. If an STI is isolated, refer to specific treatment guideline for retesting and contact tracing
Severe PID	Refer to hospital for intravenous antibiotics.	
Pregnant woman with PID	As there is a high risk of maternal morbidity and premature delivery associated with PID in pregnancy, consider inpatient admission for intravenous antibiotics.	
Woman with intrauterine contraceptive device (IUCD)	Consider removing the IUCD in women with mild to moderate PID if there is no clinical improvement at 72 hours. Women with severe PID with an IUCD in situ should be referred to hospital.	

Contact tracing & partner management

Current sexual partners should be tested for STIs and offered treatment at the first visit with **doxycycline 100mg PO, twice daily for 7 days.**