

PELVIC INFLAMMATORY DISEASE (PID) V2.0

Comments from the Expert Advisory Group

1. Pelvic Inflammatory Disease (PID) is usually the result of infection ascending from the endocervix causing endometritis, salpingitis, parametritis, oophoritis, tubo-ovarian abscess and/or pelvic peritonitis. Occasionally it is caused by local spread within the peritoneal cavity.
2. Chlamydia, gonorrhoea, trichomonas and *Mycoplasma genitalium* can lead to PID though many cases of PID are negative for these organisms. The presence of other commensal anaerobic genital tract bacteria is believed to be important in facilitating ascent of lower genital tract infections leading to PID.
3. Symptoms vary from mild to severe where hospitalisation and consideration for surgical intervention is required.
4. Mild symptoms include – lower abdominal/pelvic pain, deep dyspareunia, a change in [vaginal discharge](#), post-coital bleeding.
5. Severe symptoms include – all of the above and in addition, there may be evidence of sepsis, constitutional symptoms, shoulder tip pain, right upper quadrant pain (perihepatitis, Fitz-Hugh Curtis Syndrome).
6. Features on examination include lower abdominal/pelvic tenderness, rebound tenderness, lower abdominal/pelvic mass (in the setting of a tubo-ovarian abscess), cervical excitation tenderness on bimanual examination.
7. In patients presenting with any of the symptoms above it is important to consider the diagnosis of PID and take a sexual history.
8. A diagnosis of PID should be made on clinical grounds. Do not delay making a diagnosis and initiating treatment whilst waiting for the results of laboratory tests. Negative swab results do not rule out a diagnosis of PID.
9. Suspected cases of PID should generally be referred to a GUM clinic. Some patients will need to be referred to the Emergency Department depending on the severity of symptoms.
10. All women presenting with symptoms and/or signs suggestive of PID should have a pregnancy test performed. Suspected cases of PID in a pregnant woman should generally be referred to the Emergency Department.
11. All women presenting with symptoms and/or signs suggestive of PID should have testing for STIs including HIV, hepatitis B, syphilis, gonorrhoea, chlamydia, trichomonas and *Mycoplasma genitalium* where possible before commencing antibiotics. Antibiotic treatment should be initiated while awaiting the results.
12. Where possible, all patients being treated for PID should also have a culture taken for gonorrhoea sensitivity testing at the time of treatment. An endocervical swab sent in charcoal without delay is the test of choice in general practice.
13. *Mycoplasma genitalium* and trichomonas can be tested on the same NAAT sample that tests for gonorrhoea and chlamydia. Patients with positive *Mycoplasma genitalium* swabs should be referred to a specialist GUM clinic for management given the high prevalence of antimicrobial resistance identified in this organism.
14. [Hepatitis C \(HCV\) testing](#) should be considered part of routine sexual health screening in the following circumstances: gay, bisexual and other men who have sex with men (gbMSM); People living with HIV; Commercial sex workers; People who inject drugs (PWID). Partners of the above should also be considered for HCV testing.
15. Review patient within 72 hours if treating in the community. If little or no improvement, consider referral to hospital or review the diagnosis.
16. Individuals diagnosed with PID should be advised to abstain from sexual intercourse until treatment completed and where indicated their partner has been treated.
17. Where chlamydia, gonorrhoea or trichomonas have been diagnosed in patients with PID, these infections are [notifiable diseases](#). Notification process is usually initiated by the testing laboratory.

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Treatment

Empiric antibiotic treatment should be directed against chlamydia, gonorrhoea and anaerobic organisms. Outpatient treatment with a combination of oral and intramuscular antibiotics is appropriate for the majority of cases.

Admission to hospital and parenteral therapy is indicated in patients with evidence of sepsis, those unable to tolerate oral therapy and / or those likely to require surgical intervention (for example tubo-ovarian abscess).

Patients with a positive *Mycoplasma genitalium* result should be referred to a specialist GUM clinic. Please refer to the chlamydia and gonorrhoea pages for further management information.

PELVIC INFLAMMATORY DISEASE ANTIMICROBIAL TREATMENT TABLE

Drug	Dose	Duration	Notes
1st choice options- Note triple therapy indicated			
Ceftriaxone PLUS	1 g deep intramuscular (IM) injection	Single dose	Cephalosporins should not be used in severe penicillin allergy. Dissolve 1g ceftriaxone in 3.5 mL of 1% lidocaine injection for IM injection. Not for intravenous (IV) injection.
Doxycycline PLUS	100 mg oral every 12 hours	14 days	Contraindicated in pregnancy. Risk of photosensitivity. Advise to take with a glass of water and sit upright for 30 minutes after taking. Absorption significantly impaired by antacids, iron/ calcium/ magnesium/zinc-containing products. Separate by at least 3 hours.
Metronidazole	400 mg oral every 12 hours	14 days	Advise patients to avoid alcohol during metronidazole therapy and for 48 hours after stopping.

Cephalosporin Allergy

In patients who are allergic to cephalosporins in whom gonorrhoea is strongly suspected or confirmed, discuss with a specialist in Genitourinary Medicine or Infectious Diseases.

Other information

- [National guidelines for the prevention and control of gonorrhoea and for minimising the impact of antimicrobial resistance in *Neisseria gonorrhoeae*](#)
- [Guidance on *Mycoplasma genitalium* testing and management in Ireland](#)

Patient Information

- [Pelvic Inflammatory Disease Patient Information Leaflet.](#)
- [Information on the free HSE home STI testing service](#)