

# GYNAECOLOGY & OBSTETRICS UPDATE

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## Management of Pelvic Inflammatory Disease (PID)

**PID is a common cause of morbidity and accounts for 1 in 60 GP consultations by women under the age of 45. Delays of only a few days in receiving appropriate treatment markedly increase the risk of sequelae, which include infertility, ectopic pregnancy and chronic pelvic pain.** PID is usually the result of infection ascending from the cervix (e.g. *Chlamydia*, *gonorrhoeae*, anaerobes and other organisms). The RCOG has recently published the following recommendations:

**Due to the lack of definitive clinical diagnostic criteria, a low threshold for empirical treatment of PID is recommended.** The clinical features suggestive of PID are: lower abdominal pain & tenderness, deep dyspareunia, vaginal or cervical discharge, adnexal tenderness, & fever (>38°C).

**In mild or moderate PID (in the absence of a tubo-ovarian abscess), there is no difference in outcome when patients are treated as outpatients or admitted to hospital. The following antibiotic treatment should be commenced in primary care as soon as the diagnosis is suspected: oral Ofloxacin 400 mg twice a day plus oral metronidazole 400 mg twice a day for 14 days** to cover *Chlamydia*, *gonorrhoeae*, anaerobes. Ofloxacin should be avoided in young women when bone development is still occurring however BNF recommends that Ofloxacin can be used in children where other options are limited. Doxycycline can be safely used in children over the age of 12 years.

**Admission to hospital would be appropriate in the following circumstances:** surgical emergency cannot be excluded, clinically severe disease, tuboovarian abscess, lack of response to oral therapy, intolerance to oral therapy, suspected infection during pregnancy

**Women with suspected PID should be screened for gonorrhoea and Chlamydia.** A positive result strongly supports the diagnosis of PID, but the absence of infection does not exclude PID.

**A pregnancy test should be performed in all women suspected of having PID to help exclude an ectopic pregnancy.** In an intrauterine pregnancy, PID is extremely rare, except in the case of septic abortion. Cervicitis may occur, however, and is associated with increased maternal and fetal morbidity. Erythromycin and Amoxycillin are not known to be harmful in pregnancy.

**An intrauterine contraceptive device (IUCD) may be left in situ in women with clinically mild PID but should be removed in cases of severe disease.**

**Current sexual partners of women with PID should be contacted and offered health advice and screening (or therapy if screening is not possible) for gonorrhoea and chlamydia.** Patients should avoid intercourse until they and their partner have completed the treatment course. Referral of the index patient and her partner to a genitourinary medicine clinic is recommended.

**Patients should be provided with a detailed explanation of their condition, with particular emphasis on the long-term implications for the health of themselves and their partner(s).**

**In the outpatient setting, review at 72 hours is recommended** to ensure: adequate clinical response to treatment, compliance with oral antibiotics and Screening and treatment of sexual contacts.

**Women with PID who are also infected with HIV should be treated with the same antibiotic regimens as women who are HIV negative.**

**Women taking the oral contraceptive pill who present with breakthrough bleeding should be screened for genital tract infection, especially *Chlamydia* due to an increased incidence of asymptomatic cervical infection. Women using the oral contraceptive pill should be warned that its effectiveness may be reduced when taking antibiotic therapy.**

**Reference:** RCOG  
Clinical Green Top  
Guidelines number 32,  
May 2003

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