Pelvic inflammatory Disease (PID)

BACKGROUND

In areas of high STI prevalence, Pelvic inflammatory Disease (PID) is a common cause of low abdominal / pelvic pain in women of child bearing age. It is often unrecognised and untreated, with serious consequences for the woman including pain, discomfort and menstrual disturbance in the short term, and chronic pain and infertility in the longer term.

It is important to maintain a high level of suspicion and a low threshold for treatment in any woman of child bearing age presenting with symptoms of low abdominal pain with or without other STI symptoms.

ASSESSMENT

The diagnosis of PID is made on the basis of clinical signs and symptoms, with exclusion of other serious medical or surgical conditions. Negative chlamydia or gonorrhea test results do NOT exclude a diagnosis of PID - a clinical diagnosis of PID should prompt treatment without waiting for test results.

History

Assess STI risk

- Young age alone (15 to 30) is strongly associated with STI risk and likelihood of PID
- Outside of this age range, consider other risk factors for STI

History of presenting symptoms and presence of other symptoms

- Commonly presents at time of menstruation, post partum or after instrumentation of the genital tract
- Typically PID presents as mild to moderate low abdominal or pelvic pain, either alone or with other STI symptoms including abnormal bleeding, vaginal discharge
- Concurrent UTI is common causing mixed signs and symptoms (e.g. dysuria and pelvic pain)
- May progress to salpingitis or tubo-ovarian abscess with symptoms becoming more one-sided and / or severe
- If sores are present, check protocols for genital ulcers and discuss with a doctor
- Note that a rapid response to appropriate treatment helps to confirm a provisional diagnosis of PID (see treatment section)

Determine likelihood of pregnancy

- Ask
- Assess menstrual history and use of contraception
- Test - urine bHCG (see next section)

Past medical history

- Previous STIs, previous episodes of PID, previous treatment
- Surgical history - including appendicectomy, previous pelvic surgery, laparoscopy

Examination

Check temp, pulse rate, BP, resp rate

Abdominal examination

- Specifically assess for localised tenderness, guarding and
- rebound tenderness

Bimanual examination (if trained)

- Assess for pain on moving the cervix and adnexae
- Assess the presence of pelvic masses

Testing

Urine pregnancy test- if positive exclude ectopic pregnancy
Urinalysis- nitrites positive and/or urinary symptoms (dysuria, frequency) send MSU for MCS and also treat for UTI

If speculum and bimanual examination performed

- Endocervical swab for chlamydia, gonorrhoea and trichomonas PCR
- Endocervical swab for MCS
- High vaginal swab for MCS

Speculum examination not performed

• SOLVS OR FVU for gonorrhoea, chlamydia and trichomonas PCR, AND SOLVS for MCS

Blood test

• Syphilis serology, HIV serology, Hep B and Hep C serology if indicated (note: Hep B testing is not needed if Hep B immune (cAb positive and sAg negative) or if adequately vaccinated)
• Check if any other blood tests are due

FURTHER ASSESSMENT AND INVESTIGATION

Discuss urgently with doctor if any of the following are present

- Pregnancy confirmed or suspected
- Symptoms are severe, vomiting, unwell, temperature over 38.50C
- Significant one sided pain
- Symptoms are recurrent or persistent despite recent treatment
- Rebound tenderness present on abdominal examination

Distinguishing between PID and other causes of moderate to severe pelvic pain (eg appendicitis) may be difficult, but giving treatment to cover PID while awaiting further assessment **may lead to rapid response and prevent unnecessary invasive procedures.** Test as above and consider giving initial treatment with Azithromycin 1g and Ceftriaxone 500mg IMI or IV while arranging further assessment

MANAGEMENT

Initiate treatment and contact tracing at presentation if PID is likely and other causes have been excluded:

- Pregnancy test is negative
- Pregnancy test is positive and ectopic excluded
- Ovarian cyst/tumour is unlikely or excluded
- AND Ceftriaxone 500mg IMI as a single dose

© Kimberley Aboriginal Medical Services Council (KAMSC) and WA Country Health Service (WACHS) Kimberley

VC - Last Modified: October 14, 2011 11:50 AM

Pelvic inflammatory Disease (PID)

Initial Treatment

(1) Azithromycin 1g as a single dose; AND Ceftriaxone 500mg IMI as a single dose

If allergic to penicillin, discuss with doctor. Treatment options include: (a) Non-pregnant: Azithromycin 1g orally single dose

PLUS Ciprofloxacin 500mg single dose; (b) Pregnant:

Azithromycin 2g as a divided dose

Continue treatment with:

(2) Metronidazole 400mg twice a day OR Tinidazole 500mg daily for 14 days

- If medication adherence is likely to be a problem, offer 2g metronidazole OR 2g tinidazole as stat dose instead
- Tinidazole can not be used in during pregnancy or lactation
- Advise re avoidance of alcohol during treatment

PLUS

(3) Azithromycin 1g as a single dose 7 days after the initial dose

Follow up including contact tracing

- Advise to return within 48 hours if pain does not improve significantly or worsens.
- Test and treat contacts for chlamydia and gonorrhoea as soon as possible. Advise to abstain until contact(s) are treated.
- Provide condoms and information on transmission and prevention of STIs
- Complete an STI case management form

Follow up at 7 days:

- if good response to treatment, give second dose of
- Azithromycin as above. Enter on recall system for repeat STI check in 3 months (PCR and bloods)
- If no or limited response to treatment, consider another cause. Discuss with doctor, for referral for pelvic ultrasound and laparoscopy

RECURRENT OR CHRONIC PELVIC PAIN

- Re-infection with chlamydia and gonorrhoea is common among women presenting with PID if their contact(s) were not treated and/or they have had a new partner.
- Women with re-infection will commonly represent with a history of (a) rapid response to initial treatment for PID, followed by recurrence of low abdominal pain 3-6 months later
- **If re-infection is likely** – retreat for PID and ensure contact (s) are treated
- **PID is unlikely if there was no or limited response of pain** to appropriate treatment and contact(s) were treated and no new partners - Rethink the diagnosis and discuss with the doctor. **REFER** for pelvic ultrasound and gynaecology review (laparoscopy)

PELVIC INFLAMMETRY DISEASE

© Kimberley Aboriginal Medical Services Council (KAMSC) and WA Country Health Service (WACHS) Kimberley

VC - Last Modified: October 14, 2011 11:50 AM

Flow chart 4. Women 15-40 years presenting with low abdominal (pelvic) pain

TAKE HISTORY

- Presenting symptoms, presence of other genito-urinary symptoms
- Menstrual history, contraception and risk of pregnancy
- Risk of STI
- Medical and past history

EXAMINE

- Abdominal examination
- Bimanual examination (if possible)

TESTS:

- Urine pregnancy test
- Urinalysis
- STI testing - see page 1 of this protocol

Pregnancy test positive OR severe symptoms OR significant one sided pain

Discuss with Doctor urgently.

Refer for pelvic ultrasound to exclude:

- Ectopic pregnancy
- Ovarian mass/ ruptured cyst

Initiate treatment (pre-U/S)

Azithromycin 1g orally and Ceftriaxone 500mg IMI or IV to cover

Nitrites positive and/or dysuria/ frequency

Send urine for MCS, treat for UTI AND continue to follow flow chart

Make provisional diagnosis of PID IF:

Low abdominal (pelvic) pain only OR with other signs or symptoms of STI (abnormal bleeding, discharge) AND

- Pregnancy test is negative
- Pregnancy test is positive and ectopic excluded
- Ovarian mass is unlikely or excluded
- Pain is elicited on moving the cervix and/or adnexae (If bimanual examination performed)

Treatment – check allergies before treating, discuss with doctor if allergic to penicillin

Initial treatment

(1) Azithromycin 1g as a single dose AND Ceftriaxone 500mg IM as a single dose
See page 1 of this protocol if allergic to penicillin
Continue with:

2) Metronidazole 400mg twice a day OR Tinidazole 500mg daily for 14 days
If medication adherence is likely to be a problem, offer 2g metronidazole OR 2g tinidazole as stat dose instead
NB: tinidazole can not be used in during pregnancy or lactation
Advise re avoidance of alcohol during treatment

3) Azithromycin 1g as a single dose given 7 days after the initial dose

CONTACT TRACING AND FOLLOW UP

Advise to return within 48 hours if pain does not improve or worsens

- Recall in 7 days: check adherence to medication, check response of pain to treatment
- Review test results. Positive results are helpful, but negative results on STI testing do not exclude the diagnosis of PID

No or limited change 7 days after treatment

- Alternative diagnosis likely
- Discuss with Doctor -->

Refer for pelvic ultrasound AND laparoscopy

GOOD RESPONSE

- PID likely diagnosis
- Give second dose of Azithromycin 1g (as above)

- Complete an STI case management form
- Ensure contact(s) have been tested and treated
- Enter on recall system for a repeat STI check (PCR and bloods) at 3 months

RECURRENT LOW ABDOMINAL PAIN

Recurrence of low abdominal pain after initial rapid response to treatment: re-infection likely

- Discuss with Doctor
- Return to beginning of flow chart