

Pelvic Inflammatory Disease (PID) – RD 13

DEFINITION

PID comprises a spectrum of inflammatory disorders of the upper genital tract in women and may include any combination of endometritis, salpingitis, tubo-ovarian abscess and pelvic peritonitis. STIs are implicated in the majority of cases; however, micro-organisms that can be part of the vaginal flora can also cause PID. No single historical, physical, or laboratory finding is both sensitive and specific for the diagnosis of acute PID. The greatest risk of pelvic inflammatory disease (PID) associated with the use of IUD is primarily confined to the first 3 weeks after insertion. Diagnosis can be difficult as some women have minimal or vague symptoms, untreated PID can have significant long-term complications.

SUBJECTIVE

May include:

1. Atypical symptoms or no symptoms
2. History of fever and/or chills and pelvic pain with onset immediately before, during or following menses
3. Severe lower abdominal pain
4. Purulent vaginal discharge
5. Nausea
6. Malaise
7. Dysuria
8. Dyspareunia
9. Abnormal vaginal bleeding
10. History of Gonorrhea or Chlamydia

OBJECTIVE

May include:

1. Cervical motion tenderness, uterine or adnexal tenderness (See Plan # 1 for presumptive treatment of symptoms)
2. Oral temp >101 F (>38.3 C)
3. Abnormal cervical or vaginal mucopurulent discharge or cervical friability

LABORATORY

May include:

1. Presence of abundant WBCs on saline microscopy of vaginal secretions. PID considered unlikely with normal cervical discharge and no WBCs on wet prep
2. Gonorrhea and Chlamydia testing
3. HIV screen is recommended by CDC for all women diagnosed with PID
4. Elevated Sed Rate
5. Elevated C-reactive protein

ASSESSMENT

Pelvic Inflammatory Disease (PID)

PLAN

1. Presumptive treatment for PID should be initiated in sexually active young women and other women at risk for STD's if they are experiencing pelvic or lower abdominal pain, if no cause for the illness other than PID can be identified, and if one or more of the following minimum criteria are present on pelvic examination.
 - a. cervical motion tenderness
 - b. uterine tenderness
 - c. adnexal tenderness

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- d. Oral temperature above 101 degrees
2. Outpatient: In women with PID of mild or moderate clinical severity, parenteral and oral regimens appear to have similar efficacy. Recommended intramuscular/oral regimens:
 - a. Ceftriaxone 500 mg IM in a single dose PLUS (* Give 1 gm Ceftriaxone if weight is
➤ 150 kg or 330 #)
 - b. Doxycycline 100 mg orally twice a day for 14 days WITH
Metronidazole 500 mg orally twice a day for 14 days
OR
 - c. Cefoxitin 2 g IM in a single dose and Probenecid, 1 g orally administered concurrently in a single dose PLUS
Doxycycline 100 mg orally twice a day for 14 days WITH
Metronidazole 500 mg orally twice a day for 14 days
OR
 - d. Other parenteral third-generation cephalosporin (e.g., ceftizoxime or cefotaxime) PLUS
Doxycycline 100 mg orally twice a day for 14 days WITH
Metronidazole 500 mg orally twice a day for 14 days
3. Follow-up examination should be performed within 72 hours to assess for clinical improvement.
4. IUD users do not need removal of device at diagnosis. If they fail to respond to treatment in 48-72 hours, then consider removal.
5. If it's decided to remove IUD, antibiotics should have been initiated prior to removal. IUD should be sent for culture if patient failed antibiotic treatment.
6. The decision to refer should be based on provider judgement and whether the woman meets any of the following suggested criteria: surgical emergencies (e.g., appendicitis) cannot be excluded; tubo-ovarian abscess; pregnancy; severe illness, nausea and vomiting, or high fever; unable to follow or tolerate an outpatient oral regimen; or no clinical response to oral antimicrobial therapy.
7. Repeat testing for chlamydia and gonorrhea in women with documented PID 3 months after treatment. If retesting at 3 months is not possible, these women should be retested whenever they present for medical care in the 12 months following treatment.
8. Male sex partners (in the past 60 days) of women with PID should be examined, screened, AND treated for chlamydia and gonorrhea.

CLIENT EDUCATION

1. Provide client education handout(s). Review symptoms, treatment options, and medication side effects.
2. Total pelvic rest (no sex, douching, tampons) until completion of medicine.
3. Abstain from intercourse until self and sexual partners have completed treatment.
4. Advise client to seek immediate medical care if symptoms become worse after initiating treatment.
5. Stress the need for sexual partner(s) to seek diagnosis and treatment of STIs.
6. Counsel on safer sex education, as appropriate.
7. Advise client RTC in 72 hours and PRN for problems.
8. Discuss possible infertility risks with recurrent episodes of PID.

CONSULT / REFER TO PHYSICIAN

1. Clients meeting any criteria in #6 in the Plan section above.
2. Clients who are HIV positive may require more aggressive management (i.e., hospitalization and parenteral antibiotics)
3. Any client with medication sensitivity to recommended therapies.
4. Client not responding to therapy within 72 hours.
5. Non-compliance with completion of medications.
6. Symptomatic clients after completion of medications.
7. Refer any patient who is pregnant for immediate care and hospitalization.

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REFERENCES

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2. CDC STI Treatment Guidelines, 2021
3. Pelvic Inflammatory Disease - CDC Fact Sheet
4. CDC - PID Treatment

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