Pelvic Inflammatory Disease (PID)

**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. STDs 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.

**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, may have vomiting.
6. Malaise
7. Dysuria
8. Dyspareunia
9. Abnormal vaginal bleeding.
10. History of Gonorrhea or Chlamydia.

**OBJECTIVE**

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.

1. cervical motion tenderness
2. uterine tenderness
3. adnexal tenderness

May include:
1. Oral temp >101 F (>38.3 C)
2. 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. Vaginitis/cervicitis testing as indicated. (e.g., 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. 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 250 mg IM in a single dose PLUS
      i. Doxycycline 100 mg orally twice a day for 14 days WITH OR WITHOUT Metronidazole 500 mg orally twice a day for 14 days OR
      ii. Cefoxitin 2 g IM in a single dose and Probenecid, 1 g orally administered concurrently in a single dose PLUS
         i. Doxycycline 100 mg orally twice a day for 14 days WITH OR WITHOUT Metronidazole 500 mg orally twice a day for 14 days OR

Revised 04/2018
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<th>c. Other parenteral third-generation cephalosporin (e.g. ceftizoxime or cefotaxime) PLUS iii. Doxycycline 100 mg orally twice a day for 14 days WITH OR WITHOUT Metronidazole 500 mg orally twice a day for 14 days</th>
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<td>2.</td>
<td>Follow-up examination should be performed within 72 hours to assess for clinical improvement. 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.</td>
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<td>3.</td>
<td>Retesting for Chlamydia and Gonorrhea, in women with documented infection 3 months after treatment, regardless of whether their sex partners were treated. If retesting at 3 months is not possible, these women should be retested whenever they next present for medical care in the 12 months following treatment.</td>
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<td>4.</td>
<td>Male sex partners (in the past 60 days) of women with PID should be examined, screened AND treated for Chlamydia and Gonorrhea.</td>
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**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. | Advise client to seek immediate medical care if symptoms become worse after initiating treatment. |
| 4. | Stress need for sexual partner(s) to seek diagnosis and treatment of STDs. |
| 5. | Counsel on safer sex education, as appropriate. |
| 6. | Advise client RTC in 72 hours and PRN for problems. |
| 7. | Discuss possible infertility risks with recurrent episodes of PID. |

**CONSULT/ REFER TO PHYSICIAN**

| 1. | Clients meeting any criteria in #2 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/consult client with PID and IUD. |

**References:**