Management of Acute Pelvic Inflammatory Disease Guideline

Summary statement: How does the document support patient care?	By providing evidence based guidance for medical staff on the parameters and treatment for pelvic inflammatory disease (PID)
Staff/stakeholders involved in development:	Gynaecology medical staff, Gynaecology nursing staff, Pharmacists, Microbiologists
Division:	Women and Child Health
Department:	Gynaecology
Responsible Person:	Chief of Service
Author:	Consultant Gynaecologist
For use by:	Gynaecology medical staff, Gynaecology nursing staff, Pharmacists, Microbiologists, General Practitioners. Emergency Medicine Staff
Purpose:	To provide evidence based guidance for medical staff on the parameters and treatment for pelvic inflammatory disease
This document supports	RCOG Green-top No. 32
Key related documents:	
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If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team

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1.0	October 2013	Consultant Gynaecologist	Live	New Trust wide guideline
2.0				
3.0				
4.0				

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Management of Acute Pelvic Inflammatory Disease (PID) Guideline

1.0 Aim

To provide clear guidance for all staff caring for women with suspected or proven pelvic inflammatory disease (PID).

2.0 Scope

This guideline applies to:

- A&E staff
- Gynaecology Staff
- Women's Health doctors
- Sexual Health staff

3.0 Responsibilities

- Medical and Nursing Staff are responsible to access, read, understand and follow this guidance and to use their own professional judgement in the application of this guidance.
- Management have a responsibility to ensure the guideline is accessible to all relevant staff.

4.0 Introduction

Pelvic inflammatory disease is a result of endocervical infection causing endometritis, salpingitis, parametritis, oophoritis, tubo-ovarian abscess or pelvic peritonitis. Causative agents can be *Chlamydia trachomatis, Neisseria gonorrhoeae, Mycoplasma genitalium* or anaerobes. Delays in receiving appropriate treatment can lead to sequelae such as infertility, chronic pain and ectopic pregnancy.

5.0 Risk Factors

- Age – peak between 15 to 24 years old
- Untreated partner
- Recent change in partner
- Sexual activity
- Past history of PID/STD
- Recent IUCD insertion
- Recent termination of pregnancy
- Recent instrumentation of the uterus

6.0 Clinical features of PID

- Bilateral lower abdominal tenderness with possible radiation to the legs
- Abnormal vaginal discharge
- Pyrexia >38C
- Abnormal vaginal bleeding - inter-menstrual or post-coital bleeding or breakthrough bleeding whilst on oral contraceptive pill (OCP)
- Deep dyspareunia
- Cervical and/or adnexal excitation
- Palpable mass

7.0 Differential Diagnoses

- Ectopic pregnancy
- Appendicitis
- Endometriosis
- Irritable bowel syndrome or gastro-intestinal complaints
- Ovarian accident such as cyst torsion or rupture
- Urinary tract infection
- Chronic cyclical pelvic pain syndrome

8.0 Investigations

- FBC looking for leukocytosis
- Raised CRP or ESR
- Trans-vaginal ultrasound may aid diagnosis, especially when supported by power Doppler identifying inflamed and dilated tubes and tubo-ovarian masses.
- High vaginal, endocervical & Chlamydia swabs. It is not a prerequisite to swab prior to the initiation of treatment; however a positive result would necessitate treatment of sexual partners. Absence of confirmed cultures does not exclude PID.

There is limited evidence for CT and MRI

9.0 Management

9.1 Outpatient

Delaying treatment will likely increase the severity of the condition and increase the risk of long term sequelae. Therefore a low threshold for empiric treatment of PID is recommended.

Outpatient antibiotic therapy
Stat dose IM Ceftriaxone 500mg, po Doxycycline 100mg bd for 14 days & po Metronidazole 400mg bd for 14 days
OR po Ofloxacin 400mg BD & po Metronidazole 400mg bd for 14 days

Women should be counselled on the side effects of treatment, the risks to future fertility and the need of use of barrier contraception. She will need to be counselled that sexual partners will need screening to reduce risk of re-infection.

9.2 Inpatient

Hospital admission may be required if

- there is a lack of response to oral therapy,
- surgical intervention may be required eg drainage of tubo-ovarian abscess,
- there is clinical evidence of severe disease or the presence of a tubo-ovarian abscess,
- intolerance to oral therapy and
- pregnancy

Inpatient antibiotic therapy
IV Ceftriaxone 2g OD & po Doxycycline 100mg BD & po Metronidazole 400mg bd Converted to outpatient therapy for 14 days total
OR IV Clindamycin 900mg TDS & IV Gentamicin **(2mg/kg loading dose) followed by 1.5mg/kg 3 times daily** – converted to PO Clindamycin 450mg QDS for 14 days total OR po Doxycycline 100mg bd and po Metronidazole 400mg bd for 14 days

IV antibiotic therapy should be continued until 24 hours after clinical improvement. Appropriate analgesia should be provided.

Laparoscopy maybe required for adhesiolysis or the drainage of a pelvic abscess.

Patients should be advised to avoid unprotected intercourse until both them, and their partner(s), have completed treatment and follow-up.

A detailed explanation of their condition with particular emphasis on the long term implications for the health of themselves and their partner(s) should be provided, reinforced with clear and accurate written information (http://www.bashh.org/documents/4238.pdf)

10.0 PID in pregnancy

A pregnancy test should be performed on all women who have suspected PID to exclude an ectopic pregnancy. PID is associated with significant maternal and fetal morbidity therefore initial parental therapy is advised.

The risk of giving the recommended antibiotic regimen in very early pregnancy is low and likely results in failed implantation [UK National Teratology Information Service].

PID is rare in pregnancy. Drugs toxic in pregnancy, such as Tetracycline should be avoided. There are insufficient data from clinical trials to recommend a specific regimen and empirical therapy with agents effective against Gonorrhoea, Chlamydia and anaerobic infections should be considered taking into account local antibiotic sensitivity patterns (e.g. Ceftriaxone plus oral or IV Erythromycin with the possible addition of oral or IV Metronidazole 500mg tds in clinically severe disease).

11.0 Complications

Women with HIV may develop more severe symptoms associated with PID but respond well to standard antibiotic therapy. No change in treatment recommendations compared to HIV uninfected patients is required.

Fitz-Hugh-Curtis syndrome comprises of abdominal pain with peri-hepatitis, peri-appendicitis or peri-sigmoiditis, in women with PID.

Women with PID and an IUCD, without symptomatic improvement after 72 hours may require the IUCD to be removed. The decision to remove the IUCD needs to be balanced against the risk of pregnancy in those who have had otherwise unprotected intercourse in the preceding 7 days. Hormonal emergency contraception may be appropriate for some women in this situation.

12.0 Sexual Partners

Partners should be contacted and advised to attend their nearest Sexual Health Clinic for appropriate investigation and treatment. A completed referral form (Appendix A) should be faxed to the nearest sexual health clinic.

Partners should avoid sexual intercourse until the course of treatment has been completed.

13.0 Follow up

A review at 72 hours is recommended if a woman presents with a moderate to severe presentation of PID, to evaluate for clinical improvement.

Further review at the Fletcher Unit, Chichester or Worthing Sexual Health or Central Clinic may be necessary to ensure antibiotic compliance, adequate clinical response, screening and treatment of sexual contacts and exclude pregnancy (Appendix 1).

Persisting infections may require repeat testing for Chlamydia or gonorrhoea.

14.0 Auditable Standards

The auditable standards for this guideline are contained within the Maternity Standards Audit Document.

References

Royal College of Obstetricians and Gynaecologists Green-top Guideline No.32 Management of Acute Pelvic Inflammatory Disease

British Association for Sexual Health and HIV. Clinical Effectiveness Group. UK National Guideline for the Management of Pelvic Inflammatory Disease. 2011 http://www.bashh.org/documents/3572.pdf

Appendix 1

Pelvic Inflammatory Disease Referral to Sexual Health for further screening / partner notification			
Patient Name:		Hospital Number:	
DOB:		Date of diagnosis:	
Microbiological investigations:			
Chlamydia			
Date	Site of sample	Result	
Gonorrhoea			
Date	Site of sample	Result	
Other			
Date	Site of Sample	Result	
Antibiotic regimen prescribed & date commenced			
Other relevant info eg removal IUCD / pregnancy etc			
Referring Dr:		Bleep / contact number:	
Please FAX to relevant department:			
Fletcher unit, St Richards Hospital Spitalfields lane Chichester PO19 6SE Tel: 01243 831607 Fax: 01243 831606	Sexual Health Worthing 45 Rowlands Road Worthing BN11 3JN Tel: 01903 285199 Fax: 01903 236078	Crawley Sexual Health Clinic 5th Floor Crawley Hospital West Green Drive Crawley RH11 7DH Telephone 01293 600459 Fax: 01293 600405	