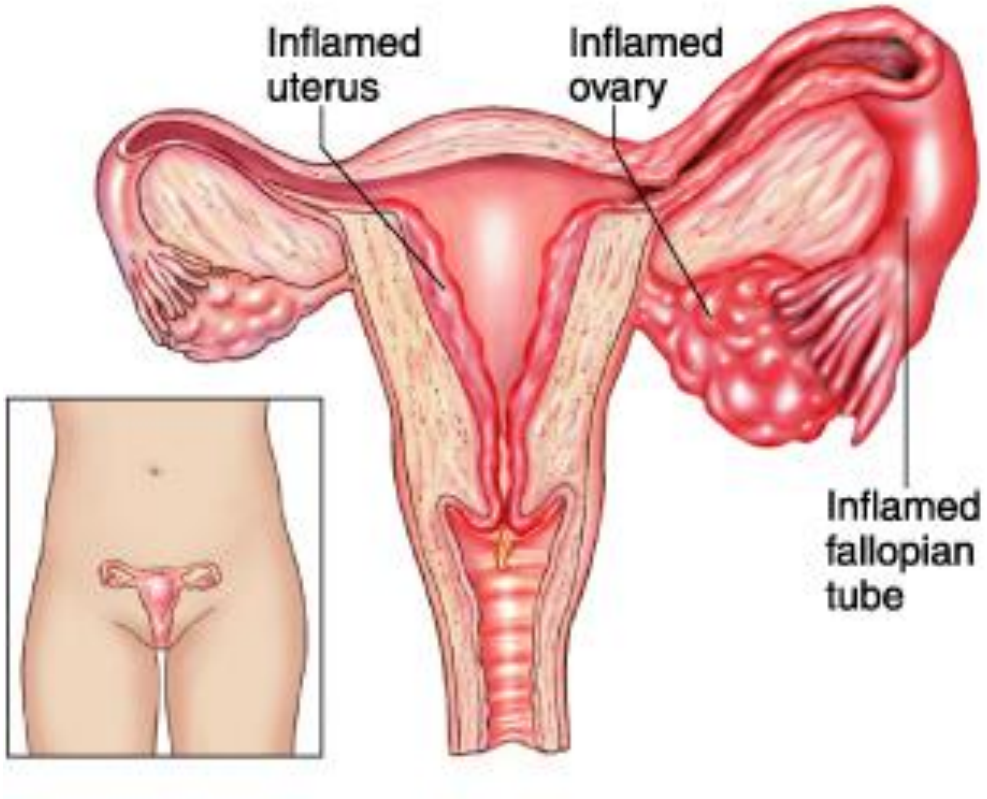
PELVIC INFLAMMATORY DISEASE



PID

Pelvic inflammatory disease is characterized by **inflammation and infection arising from the endocervix** leading to;

- endometritis
- salpingitis
- oophoritis
- pelvic peritonitis
- Subsequently formation of tubo-ovarian and pelvic abscesses

PID

Common infections -

- *Chlamydia trachomatis*
- *Neisseria gonorrhoea*

Other-

- Bacterial vaginosis

PATHOPHYSIOLOGY

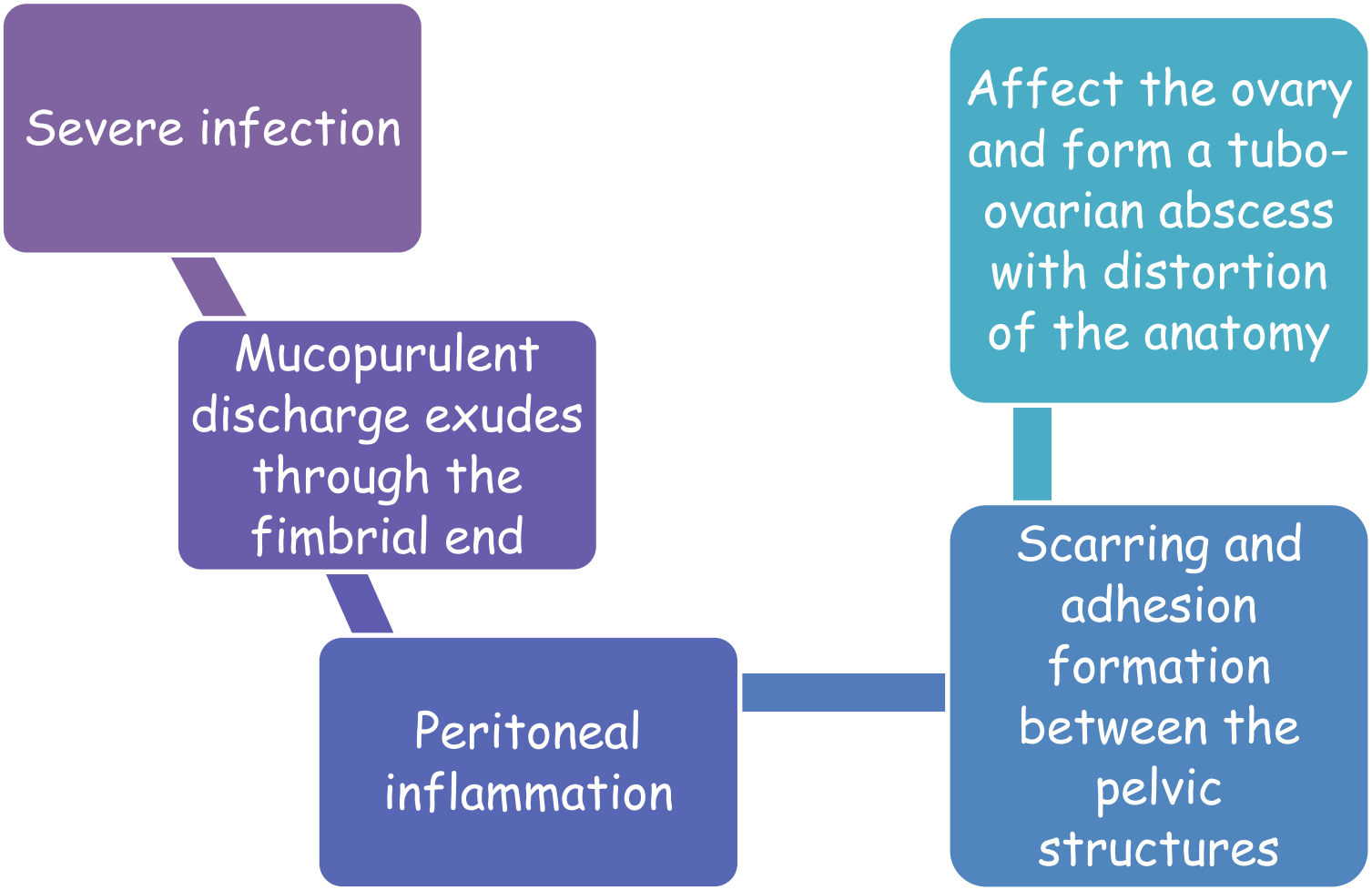
Infection ascended to the upper genital tract

Inflammation destroy the cilia within the fallopian tube

scarring in the tubal lumen

Pocketing within the lumen with partial obstruction and thus predispose to ectopic pregnancy

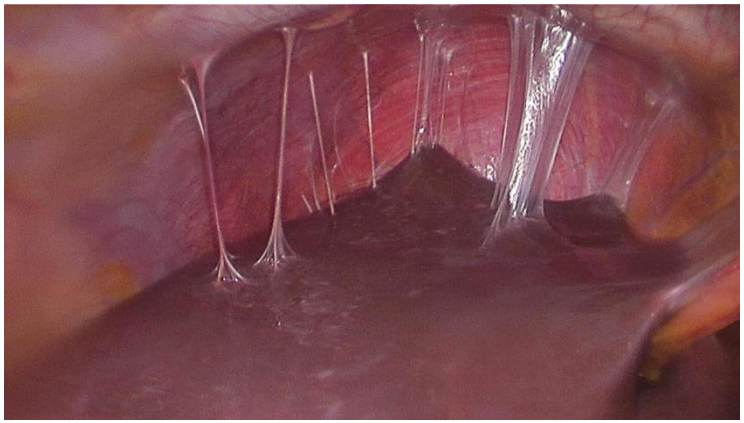
PATHOPHYSIOLOGY



Fitz-Hugh-Curtis syndrome

- Chlamydia and gonorrhoea can also cause perihepatitis leading to adhesions between the liver and the peritoneal surface.

- This gives a typical violin string appearance at laparoscopy and is known as the **Fitz-Hugh-Curtis syndrome**



PID

SYMPTOMS
Asymptomatic
Pelvic pain (may be unilateral), constant or intermittent
Deep dyspareunia
Vaginal discharge
Irregular and/or more painful menses.
Fever (unusual in mild/chronic PID)
Postcoital bleeding
Intermenstrual bleeding

SIGNS
Cervical motion pain
Adnexal tenderness
Elevated temperature >38°C
Palpable pelvic mass

HIV positive women may have more severe symptoms

INVESTIGATIONS

- Tests for gonorrhoea and chlamydia
  Triple swabs

High vaginal	• Trichomonas vaginalis • Candida • Bacterial vaginosis
Endocervical	• Gonorrhoea • Chlamydia
Urethral	• Gonorrhoea • Chlamydia

INVESTIGATIONS

- ↑WCC ↑CRP ↑ESR
- USS may be indicated if a tubo-ovarian abscess is suspected
- Laparoscopy is the gold standard test

MANAGEMENT

Depending on the severity of the infection.

Patients should be admitted to the hospital when there is evidence of:

- Severe infection
- Adnexal masses suspicious of abscess
- Generalized sepsis
- Poor/inadequate response to oral treatment
- Severe pelvic/abdominal pain requiring strong analgesics.

MANAGEMENT

Outpatient management

IM ceftriaxone 500mg stat + oral doxycycline 100mg bd 14 days + oral metronizadole 400mg bd 14 days; or

Ofloxacin orally 400mg bd 14 days + metronidazole 400mg bd 14 days (avoid if high risk of gonococcal disease).

Inpatient management

I V ceftriaxone 2g od + IV doxycycline 100mg bd, followed by oral doxycycline 100mg bd 14 days + oral metronidazole 400mg bd 14 days; or

I V clindamycin 900mg tds + IV gentamicin 2mg/kg loading dose followed by 1.5mg/kg tds, followed by either oral clindamycin 450mg qds for a total of 14 days or oral doxycycline 100mg bd + oral metronidazole 400mg bd for a total of 14 days; or

I V ofloxacin 400mg bd + IV metronidazole 500mg tds for a total of 14 days.

MANAGEMENT

In pregnancy,

- A combination of cefotaxime + azithromycin + metronidazole should be used.

- Doxycycline, gentamycin and ofloxacin should be avoided.

MANAGEMENT

Surgical treatment

•In patients with a pelvic abscess or patients not responding to therapy, a laparoscopy is warranted.

•The usual treatment would involve drainage of the abscess and sometimes the affected tube/ovary may have to be removed.

MANAGEMENT

Patient counselling

- Partner and other sexual contacts should be screened.
- There is a risk of reinfection if the partner is not treated.
- Use of barrier contraception will reduce the risk of further recurrences.
- Risks of tubal damage leading to subfertility,ectopic pregnancy and chronic pelvic pain which increases with further episodes of infection.
- Prompt and early treatment will reduce the risk of subfertility.
- Seek early medical advice if pregnant, due to the risk of an ectopic pregnancy.

COMPLICATIONS

- Tubo-ovarian abscess.
- Fitz-Hugh–Curtis syndrome
- Recurrent PID.
- Ectopic pregnancy.
- Infertility.

THANK YOU