key points

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Pelvic inflammatory disease (PID) typically results from ascending infection through the endocervix, from the lower to the upper genital tract. This leads to inflammation of the endometrium, uterus, fallopian tubes, adnexal structures or pelvic peritoneum. It is extremely common and accounts for one in 60 general practice consultations by women under the age of 45 years. The long-term effects of PID include chronic pelvic pain, subfertility and ectopic pregnancy. The most common cause of PID is sexually transmitted infection. It is important to have a very high index of suspicion in any, sexually active woman, aged 16-24, who presents to general practice.

Patients with PID may be asymptomatic or may present with a spectrum of clinical symptoms including: lower abdominal pain (typically bilateral, sometimes radiating to the legs, abnormal vaginal or cervical discharge (often purulent), dysuria, deep dyspareunia and abnormal vaginal bleeding (postcoital, intermenstrual and breakthrough). A general, abdominal and pelvic examination should be performed.

It is important to consider the differential diagnosis for lower abdominal pain in a young woman before diagnosing PID. This includes: ectopic pregnancy, urinary tract infection, appendicitis, irritable bowel syndrome, endometriosis, ovarian cyst accident and functional pain. The most significant potential complication associated with PID, following symptomatic salpingitis, is tubal damage which confers a 6-10 times increased risk of ectopic pregnancy. Symptomatic salpingitis may also lead to tubal factor infertility.

Outpatient therapy is considered to be as effective as inpatient treatment for patients with clinically mild to moderate PID. Most clinical trial data support the use of IM cefoxitin, however, as this drug is not readily available in the UK ceftriaxone has been deemed a suitable alternative. Metronidazole is usually included in most outpatient regimens to cover for the presence of anaerobes. Oral antibiotics in very early pregnancy (before a positive pregnancy test) pose a low risk to the fetus.

Prompt referral for hospital admission should be undertaken, to facilitate parenteral therapy, further investigation or possible surgical intervention, in the following cases: intolerance of, or lack of response to, oral antibiotic therapy; clinically severe disease; pregnancy or concern that a surgical emergency cannot be excluded

The duration of outpatient treatment is usually 14 days. Patients should be told to avoid any form of sexual intercourse until they, and their partner(s) have completed their full course of treatment. It is good practice to use the diagnosis and/or follow-up visit, as an opportunity for health promotion and education about PID. A further follow-up appointment should also be arranged two to six weeks after completing treatment. This will allow patient compliance and outcomes to be assessed.