PELVIC INFLAMMATORY DISEASE, ANTIMICROBIAL TREATMENT

Introduction

Objective	To ensure that broad spectrum antibiotic cover is instituted until the microbiological cultures are available for women who have Pelvic Inflammatory Disease (P.I.D)
Responsibility	Gynaecology - Inpatient and Outpatient Medical Staff
Frequency	As required

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Outpatient Regime for P.I.D.

Procedure

Follow the regime below for **outpatient** care of women who have P.I.D.

IM/IV:	Ceftriaxone 250mg	**or**
PO:	Augmentin 500mg tds for 14 days	**or**
IM:	Cefoxitin 2gm administered with Lignocaine and oral Probenecid 1gm	

Plus ADD

All for Doxycycline 100mg PO for 14 days.

Add Metronidazole 400mg q.8 hourly, 5/7 to above, if additional anaerobic cover indicated

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Inpatient Regime for P.I.D.

Procedure Follow the regime below for **inpatient** care of women who have P.I.D.

Step	Action
1.	IV: Augmentin 1.2gm 8 hourly **or** IV: Cefoxitin 1.0- 2.0gm 8 hourly **All with Doxycycline 100mg PO bd for 14 days.**
2.	• Metronidazole (1gm po/rectally12 hourly) may be added if anaerobic cover of Augmentin and Cefoxitin is deemed inadequate, although in New Zealand Metronidazole seems to add very little to anaerobic cover when used with Augmentin or Cefoxitin. • Patients allergic to Penicillin or Cephalosporins: – Erythromycin 500mg IV given 6 hourly. – Clindamycin 300 mgs IV 8 hourly with Gentamicin may be used as alternative treatment following discussion with Microbiologist – Gentamicin 3-5mg/kg/day. Loading dose is used for very sick patients with normal renal function and given in the form of triple therapy along with IV Penicillin/Cefoxitin and Metronidazole. • If there is sufficient clinical improvement (usually within 48-72 hours) IV therapy can be changed to oral therapy. Sometimes antibiotics need to be changed according to susceptibility results. Lack of response warrants laparoscopy to check the diagnosis. • Clindamycin 300mgs IV tds with Gentamicin may be used as alterative treatment regimen. • If there is no clinical improvement within 48-72 hours of IV antibiotics the diagnosis should be questioned. • Afebrile IV therapy should be continued for at least 24 - 48 hours before changing to oral therapy and continued for 14 days.

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Tubo-Ovarian Abscess (TOA)

Treatment

The place for conservative management of TOA is now well established. The criteria includes:

- Size of abscess <8cm
- Absence of overwhelming sepsis.
- Non immuno compromised patient e.g. not diabetic or on steroids.

Antibiotic Regime

Intravenous therapy and added anaerobic cover of metronidazole or Clindamycin is required. IV therapy is generally instituted for up to 72-96 hours before changing to oral therapy (10-14 days). If no clinical improvement is noted within 72 hours surgical intervention is indicated. There is now some evidence that selected cases may be managed laparoscopically.