Pelvic inflammatory disease (PID) and tubo-ovarian abscess (TOA) antimicrobial management

Document Type	Guideline
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Directorate(s)	Women's Health
Department(s) affected	Gynaecology
Applicable for which patients, clients or residents?	Gynaecology inpatients
Applicable for which staff members?	All gynaecology clinicians
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Contents

1. Purpose of guideline

The purpose of this guideline is to ensure appropriate management of patients with pelvic inflammatory disease or tubo-ovarian abscess.

2. Guideline management principles and goals

All sexual contacts within the last two months should be advised to have a sexual health check and treatment.

All recommended doses assume normal renal and hepatic function. For dose adjustments please consult with the unit or infectious diseases pharmacist.

3. Mild-moderate Pelvic Inflammatory Disease (PID) (outpatient) management

Investigations:

- first pass urine sample or vulvovaginal (and rectal if indicated) swab for chlamydia, gonorrhoea and trichomoniasis testing by NAAT
- high vaginal swab for bacterial culture
- HIV and syphilis serology
- Bimanual examination for tenderness and pelvic masses

Empiric therapy:

	Antibiotic
All patients	ceftriaxone 500 mg IM (or 1g IV) as a single dose + doxycycline 100 mg po twice daily for 14 days + metronidazole 400 mg po twice daily for 14 days

Patients should be considered for admission with PID when:

- pregnant
- not responding to outpatient therapy
- severe nausea and vomiting are present
- signs of sepsis are present
- need for surgical intervention or diagnostic exploration

4. Severe Pelvic Inflammatory Disease (PID) (inpatient) or tubo-ovarian abscess (TOA) management

Investigations:

- first pass urine sample or vulvovaginal (and rectal if indicated) swab for chlamydia, gonorrhoea and trichomoniasis testing by NAAT
- high vaginal swab for bacterial culture

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- HIV and syphilis serology
- Bimanual examination for tenderness and pelvic masses

Empiric therapy:

	Antibiotic
Beta-lactam based regimen	ceftriaxone 1g IV q24h + metronidazole 400 mg po twice daily
Non beta-lactam based regimen	clindamycin 450 mg po (600mg IV) q8h* + gentamicin 5 mg/kg (LBW) IV q24h
Oral step down therapy **to complete 14 days total treatment**	doxycycline 100 mg po twice daily + metronidazole 400 mg po twice daily

***metronidazole** is not required with clindamycin

Treatment should be reviewed at least every 48 hours and modified based on available microbiology.

PID:

If there is a lack of response at 72 hours, a laparoscopy is warranted to check the diagnosis. When there is sufficient clinical improvement, therapy can be changed to oral antibiotics to complete a total duration of 14 days.

TOA:

Conservative management of TOA should be considered when:

- abscess size <9cm
- no signs of sepsis or TOA rupture present
- premenopausal

If there is a lack of response at 72 hours surgical intervention is required, this may be laparoscopic. When there is sufficient clinical improvement, therapy can be changed to oral antibiotics to complete a total duration of 14 days - longer durations may be required dependent on response, pathogen (eg actinomyces) or abscess size. Discussion of complicated cases with Infectious Diseases is recommended.

5. Supporting evidence

- Australian STI Management Guidelines for use in Primary Care. (June 2016). Retrieved from, www.sti.guidelines.org.au
- CDC. (June 2015). Pelvic Inflammatory Disease (PID) Treatment Guidelines.
- Dewitt J., Reining A., Allsworth J. E., Peipert J. F. (2010). Tuboovarian abscesses: is size associated with duration of hospitalization & complications? *Obstetrics and gynecology international, 2010.* 847041

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- British Association of Sexual Health and HIV. (2011). UK National Guideline for the Management of Pelvic Inflammatory Disease
- LabPLUS Anaerobic Susceptibility Test Results. (2011). Retrieved from, www.labplus.co.nz
- Lareau S. M. & Beigi R. H. (2008). Pelvic inflammatory disease and tubo-ovarian abscess. *Infectious disease clinics of North America, 22(4), 693-708.*
- The New Zealand Sexual Health Society (NZSHS). (September 2017). Pelvic Inflammatory Disease Management Guidelines. Retrieved from, www.nzshs.org
- Public Health Agency of Canada. (2013). PID Guidelines
- Soper D. E. (2010). Pelvic inflammatory disease. *Obstetrics & Gynecology, 116* (1), 419-428.
- Yang C. C., Chen P., Tseng J. Y. & Wang P. H. (2002). Advantages of open laparoscopic surgery over exploratory laparotomy in patients with tubo-ovarian abscess. *The Journal of the American Association of Gynecologic Laparoscopists, 9(3), 327-332.*

6. Associated Auckland DHB documents

- Antimicrobial Stewardship - Antimicrobial Therapy

7. Disclaimer

No guideline can cover all the variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

8. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or email the Clinical Policy Advisor without delay.