Women with acute, severe pelvic pain are most appropriately assessed by a gynecologist. Chronic or recurrent pelvic pain can be notoriously difficult to diagnose and manage and although many women will eventually require a gynecological assessment, GU medicine can play an important role in assessing patients for evidence of genital infection. Referral to GU medicine may therefore be an appropriate first step for women with pelvic discomfort or pain and if no evidence of infection is found gynecological referral should then be considered.

Pelvic inflammatory disease is difficult to diagnose without the aid of laparoscopy and many women are unfortunately labeled as having PID on insufficient clinical grounds. This can lead to a great deal of anxiety, particularly regarding infertility. It is impractical to offer laparoscopy to all women with pelvic pain and if PID is considered a possible diagnosis then the uncertainty of the diagnosis should be discussed with the patient, the appropriate genital swabs taken, appropriate antibiotics prescribed, male sexual partners assessed for asymptomatic urethritis and chlamydial infection, and the patient reassessed after treatment.

*Chlamydia trachomatis* is the commonest cause of PID in the UK and although many women will present with increased vaginal discharge and pelvic discomfort/pain, there is now good evidence to suggest that *Chlamydia* can produce subclinical pelvic infection. As with classical PID, subclinical infection may cause tubal damage and subsequent infertility.

Gonorrhoea is less common in the U.K. than chlamydial infection but the diagnosis must be considered in all women with presumed pelvic infection. *Mycoplasma genitalium* has also been recently recognised as a sexually transmitted pathogen, capable of causing urethritis, cervicitis and pelvic inflammatory disease.
10.1 DIAGNOSIS AND MANAGEMENT OF PELVIC INFLAMMATORY DISEASE

(1) The following swabs should be taken:

(a) Vaginal and cervical swabs for Gram staining and microscopy. Unfortunately these are rarely performed in settings other than GU medicine clinics in the UK. Most PID results from an ascending lower genital tract infection, so there is often evidence of an abnormal vaginal microflora, such as bacterial vaginosis, or of a cervicitis. Mucopurulent cervical secretions provide clinical evidence of cervicitis; however, this is not always easy to assess unless there is excellent lighting and an experienced eye (see also chapter 6 page 29). Confirmation can be made by examining a Gram-stained smear of cervical secretions by microscopy: the presence of >30–40 polymorphs per high power field (HPF – x1000 magnification) is highly suggestive of cervicitis. A normal lactobacilli-predominant vaginal flora and the absence of cervicitis make PID a less likely diagnosis.

(b) Cervical swabs (NOT vaginal) for *Chlamydia* detection and *Neisseria gonorrhoeae* culture. Remember that organisms may be present in the uterus and fallopian tubes in spite of negative cervical cultures. Tests are currently not routinely available for diagnosing *Mycoplasma genitalium* infection.

(2) A raised ESR and peripheral white blood cell count are often present in acute PID but are non-specific and therefore provide little clinical guidance.

(3) Remember that the most important differential diagnoses for acute PID are acute appendicitis and ectopic pregnancy. Other conditions which may mimic PID include endometriosis, corpus luteum bleeding, urinary tract infection, mesenteric lymphadenitis, and ovarian tumor. The more common differential diagnoses of chronic pelvic pain include endometriosis, irritable bowel syndrome, and pelvic congestion.

(4) Treatment of PID should include antibiotics active against *Chlamydia*, anaerobes, and the gonococcus.

Possible oral combinations include the following:
- Doxycycline 100 mg bd + co-amoxiclav 500 mg tds
- Ofloxacin 400 mg bd + metronidazole 400 mg bd + ciprofloxacin 500 mg bd
- Doxycycline 100 mg bd + metronidazole 400 mg bd + cefixime 200 mg od.
At least 2–3 weeks of anti-chlamydial and anti-anaerobic treatment are recommended. Ciprofloxacin or cefixime may be stopped after 1 week. There is currently no evidence to suggest that treatment with non-steroidal anti-inflammatory drugs reduces the risk of tubal scarring.

(5) Advise bed rest and analgesia as required.

(6) It is imperative that sexual partners are assessed for evidence of urethritis and treated, otherwise recurrence is likely. Further attacks of PID increase the chances of infertility: following three episodes of PID there is a more than 50% chance of infertility. Urethritis is frequently asymptomatic in male contacts of women with PID, a point worth stressing to the patient.

(7) A number of women suffer chronic pelvic pain for which no obvious cause can be found. Underlying psychological issues should be carefully sought and discussed openly with the patient. Suggesting that symptoms are “in the mind” is usually unhelpful, whereas an approach that recognizes the symptoms as real and attempts to help the patient “de-focus” by way of hypnosis, meditation or low-dose antidepressants, as used for chronic pain relief, may prove helpful.